



AFRICA CHA PLATFORM



HIV & AIDS

COUNSELING GUIDE
FOR RELIGIOUS LEADERS



HIV AIDS

COUNSELING GUIDE FOR RELIGIOUS LEADERS



INERELA+ KENYA
International Network of Religious Leaders Living
with or personally affected by HIV - Kenya Chapter



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ISBN: 978-9966-820-09-9

ACHAP would like to thank the following for their contribution to this publication:

Lucy W. Kungu (USIU Africa); Sheikh Yusuf Nasur (SUPKEM); Maryanne Mwangi (St. Paul's University); Esther Kieya (St. Joseph the Worker Dispensary); Dr. Lucas Otvera (SDA); Fr. Joseph Mutie, Bishop Osham Ominde (OAIC); Imelda Namayi (NCCK); Roseline Warutere, Patricia K. Macharia (NASCOP); Aziza Gulam (NAMLEF); Fr. Francis Maina (Nairobi Hospital); Dr. Bethseba Osoro, Christine Njogu (NACC); Eddy Mungoni, Fr. Lucas Manwa (KCCB); Rev. Jane Ng' ang'a, Bishop James Okombo (INERELA+); Sara Mellilo (IMA World Health); Nicholas Musembi, Rose Koki Mutuku, Ann Mwebia (Gospel Parliament); Rev. Jason Kabera (GECK); Rev. Connie Kivuti (EAK); Dr. Samuel Mwenda, Dr. Mugo Godwin, Tabitha Rono, Bramwel Siku (CHAK); Dr. Charity Waithima (African Nazarene University); Nkatha Njeru, Mike Mugweru (ACHAP).

This publication was made possible by the generous support of the American people through the UNAIDS/PEPFAR-Faith Initiative. Working closely with faith-based and community stakeholders is critical to the success of UNAIDS and PEPFAR's missions. This guide was created in close collaboration with and input from religious leaders with support for medical content from medical experts from faith-based organizations, NACC, NASCOP and the academia. The religious statements and views are the sole responsibility of the authors and partners and do not reflect the views of UNAIDS, PEPFAR, or the U.S. Government.



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Definition of HIV related terms



Acquired Immunodeficiency Deficiency Syndrome (AIDS)

AIDS is the most advanced stage of the HIV infection. According to CDC, a person is deemed to have AIDS if they have a CD4 count of LESS than 200cells/mm or have an AIDS-defining condition.

Acquired resistance

When a drug-resistant strain of HIV emerges while a person is on antiretroviral therapy (ART) for the treatment of HIV infection.

Adherence

It means taking HIV medication as instructed by a healthcare provider by, for example, observing the frequency, time of the day, with or without food, etc. The benefits of strict adherence to an HIV regimen include sustained viral suppression, reduced risk of drug resistance, improved overall health and quality of life, and decreased risk of HIV transmission. On the flip side, poor adherence can lead to drug resistance.

Antiretroviral drugs (ARVs)

The drugs used to prevent a retrovirus such as HIV from replicating. The term primarily refers to antiretroviral (ARV) HIV drugs that improve the immune system, keeps the virus at low levels and reduces the likelihood of passing the virus to someone else.

Antiretroviral Therapy (ART)

Refers to the daily use of a combination of HIV medicines (HIV regimen) to treat HIV infection. A person's initial HIV regimen generally includes three antiretroviral (ARV) drugs from at least two different HIV drug classes.

CD4 count

It's the measure of the number of T-helper cells (CD4 cells) in someone's blood. CD4 cells are a type of immune system cell in the body.

The HIV virus usually attacks these cells destroying them over time and weakening the immune system. The CD4 Count is usually determined through a simple blood test.

Counselor

For the purpose of this guide, this is a religious leader offering emotional, psychological and spiritual support to clients.

HIV Testing Services (HTS)

HTS refers to a range of services that should be provided in addition to HIV testing (WHO, 2016). HIV testing is the process of identifying a person's HIV status, informing them of their status and counseling them on positive living if found positive, or behavior change if found negative to minimize future HIV risk. HTS services encompass counseling (pre-test and post-test), linkage to appropriate HIV prevention measures, treatment and care, and other clinical and support services; and coordination with laboratory services to ensure high-quality, accurate results. Any form of HIV testing should also adhere to the World Health Organization's 5Cs: Consent, Confidentiality, Counseling, Correct test results and Connection (to prevention, treatment, and care services).

Human Immunodeficiency Virus (HIV)

The virus that attacks a person's immune system cells, leading to complete destruction, especially without treatment. HIV is the virus that causes AIDs.

False negative result

A false negative HIV test indicates a person does not have HIV when, in fact, the person is infected with HIV.

False positive result

A false positive HIV test indicates a person has HIV when, in fact, the person is not infected with HIV.

Perceived social support

The perception and actuality that one is cared for, has assistance available from other people, and that one is part of a supportive social network.

Post-Exposure Prophylaxis (PEP)

Short-term treatment started as soon as possible (within 72 hours) after high-risk exposure to HIV, for example through unprotected sex. The purpose of post-exposure prophylaxis (PEP) is to reduce the risk of infection.

Pre-Exposure Prophylaxis (PrEP)

A HIV prevention method for people who are HIV negative and at high risk of HIV infection. PrEP involves taking a specific combination of HIV medicines daily. PrEP is even more effective when it is combined with condoms and other prevention tools.

Seroconcordant couples

It is a situation where both partners in a relationship are HIV positive or negative. Also known as concordant couple.

Serodiscordant couples

Refers to a situation where partners have different HIV statuses, that is, one person has HIV and the other does not. Also known as discordant couple or mixed-status couple.

Undetectable viral load

When the amount of HIV virus in the blood is too low to be detected with a viral load (HIV RNA) test.

Viral load

This refers to the amount of HIV virus in a sample of blood, usually reported as the number of HIV RNA copies per milliliter of blood. The goal of ART is to suppress a person's viral load to an undetectable level (level too low to be detected by a viral load test).

Window period

The time period from infection with HIV until the body produces enough HIV antibodies to be detected by standard HIV antibody tests. The length of the window period varies depending on the antibody test used. Usually between 2 to 12 weeks.



Introduction



Counseling in the context of HIV and AIDS care is a combination of information exchange, skill acquisition and emotional support as the counselor interacts with the person infected with HIV (the client) and others significant to the client – who may include family members, friends, health practitioners, employers and people who give spiritual support.¹

The aim of HIV counseling is to help the client to cope with the stress related to HIV or AIDS and to think through personal decisions relating to HIV and AIDS services. The specific objectives of this HIV and AIDS counseling include:

- To enable the religious leader assess the client’s needs with the goal of enabling him or her to attain optimal physical, mental and social health and functioning.
- To guide the religious leader in providing ongoing support, including information, to help the client avoid transmission to others.
- To enable the religious leader to help the client to view things in a constructive, healthy way – in this case, drawing upon God.

There are a number of activities that can easily be confused with counseling but they are not. The following activities, for instance, are not counseling:

- Giving personal advice – e.g. “If I was in your situation, I would...”

¹ <http://htc.anu.edu.au/pdfs/ContinuingHIV/Irinoye.pdf>

- Judging - where you give a verdict of right and wrong.
- A quick fix - e.g. "You have no money, so I'm giving you some."
- Over-identification - where you get emotionally involved with the problems of others to the extent that aspects of your own life (sleep, work, or personal relationships, for instance) are disrupted because of the tension created by the problem shared.



Do not judge the client.

Religious leaders occupy a very unique place in society and are strategically positioned for HIV and AIDS counseling. To begin with, religious leaders enjoy a high level of trust by the community. Secondly, religious leaders are close to the people, especially in times of crisis, when people often look up to them for support and direction. The level of receptivity is high during such times and therefore conducive for information sharing and emotional support. Finally, religious leaders are involved in religious, cultural and public events where their leadership and counsel is recognized and highly valued. On such occasions, the religious leader may find opportunities to provide information that can assist in stigma reduction and enhancement of HIV service uptake.

Indeed, in their normal course of duty, religious leaders are presented with many opportunities to provide HIV counseling, directly or indirectly. These opportunities include:

1. Sermons
2. Post-sermon counseling
3. Pre/post-marital counseling sessions
4. Domestic dispute resolution counseling sessions, reconciliation proceedings
5. Crisis moments such as death, divorce, sickness, accidents, fires, political violence and terminal disease
6. Personal and family celebrations: graduations, childbirth, dowry negotiations, weddings
7. Annual events in the church calendar: conferences, conventions, regular youth/women's/men's groups or activities
8. Opportunities that exist outside religious facilities: community activities such as World AIDS Day, Day of the African Child, campaign rallies, and chaplaincy in schools, universities, hospitals, prisons

HIV and AIDS: A Topical Overview

Country Context

Kenya has the fourth largest HIV epidemic in the world with 1.6 million people living with HIV (UNAIDS, 2017). Kenya's HIV epidemic is considered "generalized," with all segments of the population (children, young people and adults) affected.

HIV prevalence rates:

5.2%
among women

4.2%
among men

Women are more vulnerable to HIV infection than men, with the national HIV prevalence at 5.2 % for women and 4.5% for men. The concentration of the epidemic also varies geographically, ranging from a high HIV prevalence of 21% in Siaya County to 0.1% in Wajir County.²

HIV and AIDS deaths:

29%
adults annually

15%
under the age of
five, annually

When it comes to new infections, adults (15 years and above) contributed the most at 85%, while young people (15 to 24 years) contributed 33% and children (14 years and below) contributed 15%.³ Married couples contributed 44% of new infections.⁴

^{2,3} Kenya HIV Estimates Report (NACC, 2018)

⁴ Kenya HIV County Profiles (NACC, 2016)

The high burden of HIV and AIDS in Kenya accounts for an estimated 29% of adult deaths annually, 20% of maternal mortality, and 15% of deaths of children under the age of five.⁵ To achieve a Kenya free of HIV infections, stigma and AIDS-related deaths, the Kenya AIDS Strategic Framework envisions a HIV response that is multi-sectoral, with key institutions at the national and county levels carrying out critical mandates synergistically to achieve joint results. To this end, the role of religious leaders and faith-based organizations in implementing workplace policies and carrying out advocacy and community mobilization for uptake of HIV prevention, treatment, care and support services cannot be overemphasized.

HIV Counseling and Testing

According to KAIS (2012), 53% of Kenyans living with HIV don't know their HIV status, 16% had never been tested (or received test results, if tested), and 37% believed they were HIV-negative based on self-reporting. HIV counseling and testing are key elements in a comprehensive response to the HIV epidemic and forms an important part of a continuum of HIV prevention and treatment services.

The first of the United Nations' 90-90-90 targets to end the HIV epidemic is for 90% of people living with HIV to learn their HIV status. It is essential to hit this target because HIV testing and counseling are the gateway to care, treatment and support for persons in need. They are also the entry points into prevention and other services. Accordingly, there is an urgent need to scale up using innovative, ethical and practical approaches to deliver HIV counseling and testing.

⁵ Kenya HIV County Profiles, 2016

HIV Transmission

HIV destroys a person's immune system by destroying CD4 cells (T cells) that fight diseases and infections. HIV has no cure but can be controlled by taking antiretroviral drugs (ARVs). Untreated, HIV reduces the number of CD4 cells in the body. This damage to the immune system makes it harder for the body to fight off infections and some other diseases. When opportunistic infections or cancers take advantage of a very weak immune system, this signals that the person has AIDS.

HIV transmission occurs when certain body fluids from a person living with HIV come into contact with a mucous membrane or damaged tissue of another person or through direct injection into the bloodstream. These body fluids include blood, semen, rectal fluids, vaginal fluids and breast milk. The spread of HIV from a woman with HIV to her child during pregnancy, childbirth, or breastfeeding is called vertical transmission or mother-to-child transmission (MTCT). HIV is however not transmitted by air or water, sweat, saliva, tears, closed mouth kissing, insects/pets, or sharing toilets, food, or drinks. HIV is mainly transmitted through:

- Unprotected sexual intercourse (either vaginal or anal) with someone who has HIV.
- Unprotected oral sex with someone who has HIV: Oral-genital contact poses a clear risk of HIV infection, particularly when ejaculation occurs in the mouth. This risk goes up when either partner has cuts or sores, such as those caused by sexually transmitted infections (STIs), recent tooth-brushing, or canker sores, which can allow the virus to enter the bloodstream.
- Sharing needles or syringes with someone who is HIV positive.
- Infection during pregnancy, childbirth, or breast-feeding (mother-to-child transmission).



An HIV positive mother may transmit the HIV virus to her child through breast feeding. With proper care and guidance, this can be avoided.

HIV Prevention

There are various ways to reduce the risk of acquiring or transmitting HIV. These include:

- Practice abstinence.
- If sexually active:
 - have only protected sex, always (i.e. use condoms consistently and correctly).
 - have sex with one partner of known status or limit the number of sexual partners.
 - use pre-exposure prophylaxis.
 - take post-exposure prophylaxis if potentially exposed to the HIV virus.
- If injecting drugs, avoid sharing needles. Use only sterilized needles and syringes.
- If HIV-positive, take ARVs consistently to prevent onward HIV transmission to sexual partners or infants.

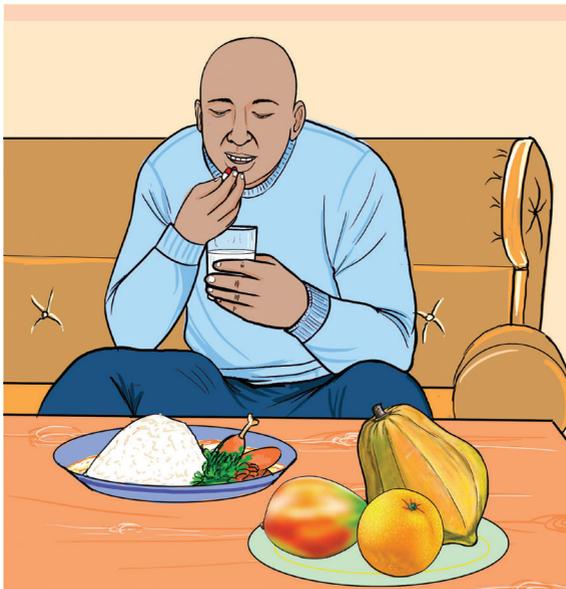
HIV Care and Treatment

HIV infection can be treated with ARVs in a treatment regimen known as antiretroviral therapy (ART). ART involves taking a combination of at least three HIV drugs every day. ART does not cure HIV infection but suppresses viral replication within a person's body and allows an individual's immune system to strengthen and regain the capacity to fight off infections (WHO, 2016). All individuals with confirmed HIV infection are eligible for ART, irrespective of CD4 cell levels, WHO clinical stage, age, pregnancy or breastfeeding status, co-infection status, risk group, or any other criteria (NASCOP, 2016).

ART Adherence

Adherence involves following the doctors' instructions and taking responsibility for personal health (NASCO, 2011). Adherence not only means sticking to the dosage and the prescribed schedule of taking medication but also sticking to the comprehensive treatment program, including doctors' appointments, hospital visits, and nutritional advice, among other components.

The benefits of adherence are profound in the lives of people living with HIV (PLHIV). With adherence, their overall quality of life improves as they become healthy and can ward off opportunistic infections. Additionally, adherence to ART leads to HIV suppression, reducing the viral load to undetectable levels, which in turn makes clients less likely to transmit HIV to others, including partners and unborn babies. Adherence also reduces the risk of the virus developing resistance to medications.



Adhering to the ART and eating well helps to reduce the viral load.

PLHIV should be supported in maintaining adherence. This support may include discussing reasons for non-adherence and exploring solutions, referring for adherence counseling and support when necessary, engaging treatment supporters/buddies such as family members or peers, and using adherence aids where available, such as reminders and pill boxes.

HIV Discordance

HIV discordance exists when one partner in a relationship is HIV positive and the other is HIV negative. The HIV positive partner may have been infected before the two became a couple, had other partners outside the relationship, had a medical exposure, injected drugs, acquired HIV through vertical transmission and survived to sexual maturity, or suffered rape or sexual abuse (NASCO, 2011). Key messages for discordant couples should be (1) correct and consistent use of condoms, (2) periodic testing, (3) adherence to medication for the HIV positive partner in order to achieve undetectable viral loads, and perceived social support for the HIV positive partner.

Disclosure

Disclosure is the revealing or sharing of one's HIV status to others, either by self or by a care provider (NASCO, 2011). Disclosure may be directed to a partner, family members, health-care workers, peers, or religious leaders, among others. According to NASCO (2011), there are various benefits of disclosure.

Disclosure may facilitate early access to care and treatment; improve adherence to care, treatment, and medications; and improve partner testing and prevention. Disclosure helps HIV-infected individuals

to receive support from their partners and other potential support systems, and it helps in fighting stigma, including self-stigma and enacted stigma.

Key considerations before disclosure should include: whom to tell, when to tell, why tell, as well as the likely reactions and how to deal with them. Persons who feel unable to disclose their status should be linked to a trained counselor to assist in the disclosure process.

HIV Stigma and Discrimination

HIV stigma is a form of prejudice that discredits or rejects an individual or group of people because of their perceived or actual HIV status. HIV-related stigma arises mostly from fear or ignorance about the disease, or hostility and prejudices against groups considered to be particularly vulnerable.

Stigma and discrimination towards people living with HIV are still of concern. According to the National HIV and AIDS Stigma and Discrimination Index Summary Report (2014), the overall composite stigma index for Kenya was high at 45%. One of the objectives of the Kenya AIDS Strategic Framework (KASF) is to reduce stigma and discrimination by 50%.



Stigma and discrimination prevent people from accessing HIV prevention, treatment, care and support services (UNAIDS, 2014). Research has shown that stigma and discrimination undermine HIV prevention efforts by making people afraid to seek HIV information services and modalities to reduce their risk of infection and to adopt safer behaviors, lest these actions raise suspicions about their HIV status.

Stigma and discrimination also discourage people living with HIV from disclosing their status to family members and sexual partners, ultimately undermining their ability and willingness to access and adhere to treatment. Therefore, stigma and discrimination can be a significant barrier for individuals and communities when it comes to protecting themselves from HIV or staying healthy if living with HIV.



Theological Basis for HIV Counseling



The involvement of religious leaders in HIV counseling should be grounded in scriptural teachings. In this section we will examine the biblical, Quran and Sunnah underpinnings of HIV counseling, while acknowledging that HIV is not specifically addressed in the Bible and Quran because of the obvious reason that it did not exist at the time of their writing. We therefore rely on the general principles of religious leaders' involvement in the health and welfare of the community.

One of the clearest examples of a religious leader involved in health services is recorded in the book of Leviticus, where the priest was in effect a public health officer. Two examples are found in Leviticus 13 and 14 .

Any suspected case of leprosy was to be confirmed by the priest, and anyone claiming to have been healed of leprosy was to subject himself or herself to examination by the priest, who had the exclusive mandate of declaring that one had been healed.

Similarly, if any patch appearing to be mold (fungus) was discovered in any building, regulations required that the priest be called to make an examination and provide appropriate directions, which could include demolition orders.

In the New Testament, Jesus, explaining his mandate and mission, declared that healing would be an important component of his work. In Luke 4:18 we read:

18 “The Spirit of the Lord is on me,
because he has anointed me
to proclaim good news to the poor.
He has sent me to proclaim freedom for the prisoners
and recovery of sight for the blind,
to set the oppressed free,
19 to proclaim the year of the Lord’s favor.”
(*New International Version*)

In John 10:10, Jesus said that “I have come that they may have life, and that they may have it more abundantly” (NKJV). As demonstrated by Jesus’ ministry, abundance of life included healthy lives. The Bible records numerous healing miracles performed by Jesus in fulfillment of His mandate. He even restored life to people who had already succumbed to their conditions and died.

Some of the notable miracles in this regard include:²

Miracle	Reference			
	Matthew	Mark	Luke	John
Jesus heals an official’s son at Capernaum in Galilee				4:43-54
Jesus drives out an evil spirit from a man in Capernaum		1:21-27	4:31-36	

² <https://www.thoughtco.com/miracles-of-jesus-700158>

Miracle	Reference			
	Matthew	Mark	Luke	John
Jesus heals Peter's mother-in-law sick with fever	8:14-15	1:29-31	4:38-39	
Jesus heals many sick and oppressed in the evening	8:16-17	1:32-34	4:40-41	
Jesus cleanses a man with leprosy	8:1-4	1:40-45	5:12-14	
Jesus heals a centurion's paralyzed servant in Capernaum	8:5-13		7:1-10	
Jesus heals a paralytic who was let down from the roof	9:1-8	2:1-12	5:17-26	
Jesus heals a man's withered hand on the Sabbath	12:9-14	3:1-6	6:6-11	
Jesus raises a widow's son from the dead in Nain			7:11-17	
Jesus heals a woman in the crowd with an issue of blood	9:20-22	5:25-34	8:42-48	
Jesus raises Jairus' daughter back to life	9:18, 23-26	5:21-24, 35-43	8:40-42, 49-56	
Jesus heals two blind men	9:27-31			
Jesus heals a man who was unable to speak	9:32-34			
Jesus heals an invalid at Bethesda				5:1-15
Jesus heals many sick in Gennesaret as they touch his garment	14:34-36	6:53-56		

Miracle	Reference			
	Matthew	Mark	Luke	John
Jesus heals a Gentile woman's demon-possessed daughter	15:21-28	7:24-30		
Jesus heals a deaf and dumb man		7:31-37		
Jesus heals a blind man at Bethsaida		8:22-26		
Jesus heals a man born blind by spitting in his eyes				9:1-12
Jesus heals a boy with an unclean spirit	17:14-20	9:14-29	9:37-43	
Jesus heals a blind, mute demoniac	12:22-23		11:14-23	
Jesus heals a woman who had been crippled for 18 years			13:10-17	
Jesus heals a man with dropsy on the Sabbath			14:1-6	
Jesus cleanses ten lepers on the way to Jerusalem			17:11-19	
Jesus raises Lazarus from the dead in Bethany				11:1-45
Jesus restores sight to Bartimaeus in Jericho	20:29-34	10:46-52	18:35-43	
Jesus heals a servant's severed ear while he is being arrested			22:50-51	

Some people raised concerns about the attention and empathy that Jesus was showing to the sick and other people in need; Jesus declared, “it is the sick who need a doctor” (Mark 2:17). His primary attention was to those who needed His help, regardless of their background. Jesus amplified this fact by giving the parable of the Good Samaritan in Luke 10:25–37. In the parable, Jesus described a good neighbor as one responding to a person in need, regardless of cultural or ethnic background. Unfortunately, in the story, the religious leaders failed as they actively avoided someone who was hurting and desperately needed their help.

From the Quran perspective, we have a number of ayah (verses) that support caring for and walking with the sick and those in need. Muslims turn to the Quran and Hadith for guidance in all areas of life, including health and medical matters. Prophet Muhammad (S.A.W.) said, “Allah did not create a disease for which He did not also create a cure.”

Muslims are therefore encouraged to explore the use of both traditional and modern forms of medicine and to have faith that any cure is a gift from Allah.

NOTE: One should always consult with a medical professional before attempting any treatment. Some herbs may be harmful in certain conditions or when consumed in the wrong quantities.

There are many hadith that encourage Muslims to seek medical treatment. Some of them are mentioned below.

Abu Hurayrah narrates that the Prophet (S.A.W.) said,

“There is no disease that Allah has created, except that He also has created its remedy.” BUKHARI 7.582

Usamah bin Shureik narrated:

“...O Allah’s messenger! Should we seek medical treatment for our illness? He replied: yes, you should seek medical treatment, because Allah, the Exalted, has let no disease exist without providing for its cure, except for one ailment, namely, old age.” TIRMIDHI

The Prophet (S.A.W.) not only instructed sick people to take medicine, but he himself invited expert physicians for this purpose (D.o.H. p.50 As-suyuti’s Medicine of the Prophet p.125).

From this brief beginning one would gather that imaan (faith) and tawakul (trust) have to be of the utmost importance to a Muslim’s belief. Hence, problems, illness or trouble of life should be very easy to cope with, but since this material world has been classed as Darul asbab (a world of means) it’s necessary to take medication for one’s illness. In many cases, muftis would give a ruling of suicide for one who died in the event of not taking medicine. We all would be required by shariah (Islamic law) to have trust in Allah but search for the cure which would be classed as the highest grade of tawakul (trust in Allah).

“Verily Allah sent down the disease and the cure, and for every disease he made a cure. Seek treatment, but do not seek treatment by the unlawful.” Abu Dawud 3874

As we guide believers on how to seek HIV treatment among other diseases, the Quran also encourages counseling support for the ailing and needy by use of different skills.

Counseling skills	Quran verses	Information
Rapport	And when (other) relatives and orphans and the needy are present at the (time of) division, then provide for them (something) out of the estate and speak to them words of appropriate kindness. (Surat an-Nisa [4]:8)	Building a good relationship right from the initial meeting is key and should receive the attention of the counselor.
Attending	And the servants of the Most Merciful are those who walk upon the earth easily, and when the ignorant address them (harshly), they say (words of) peace. (Surat al-Furqaan [25]:63)	Counselors should pay full attention to their clients; in what the client says and does. The counselor should see the client as worthy of his or her time.
Empathy	There has certainly come to you a Messenger from among yourselves. Grievous to him is what you suffer; [he is] concerned over you and to the believers is kind and merciful. (Surat at-Tawbah [9]:128)	The counselor should have empathy towards the client, but it is important that the counselor does not become too affected to do his or her job.

Counseling skills	Quran verses	Information
Leading	Responding O ye who believe, fear Allah and let every soul consider what he has done for tomorrow (hereafter), and fear Allah, surely Allah is aware of what you do. (Surat al-Hashr [59]:18)	A counselor should humble himself to the client and not dominate him or her. Throughout the counseling the counselor should lead rather than direct the client.
Responding	O ye who believe, fear Allah and let every soul consider what he has done for tomorrow (Hereafter), and fear Allah, surely Allah is Aware of what you do. (Surat al-Hashr [59]: 18)	As the counselor interacts with the client, responses towards the client's comments, questions and actions should be empathic and helpful.
Summarizing	And if you (must) turn away from the needy awaiting mercy from your Lord which you expect, then speak them a gentle word. (Surat al-Israa '[17]: 28)	Summarizing what the client has said, as well as mentioning the key points outlined, helps to ensure that he or she has not misunderstood the client. It also reassures client that the counselor was listening to him or her.

Counseling skills	Quran verses	Information
Negotiations	No good is there in much of their private conversation except for those who enjoin charity or that which is right or conciliation between people. And whoever does that seeking means to the approval of Allah – then we are going to give him a great reward. (Surat an-Nisa [4]: 114)	Encouraging action may involve negotiations between the counselor and the client in order to realize the best results from the counseling process.

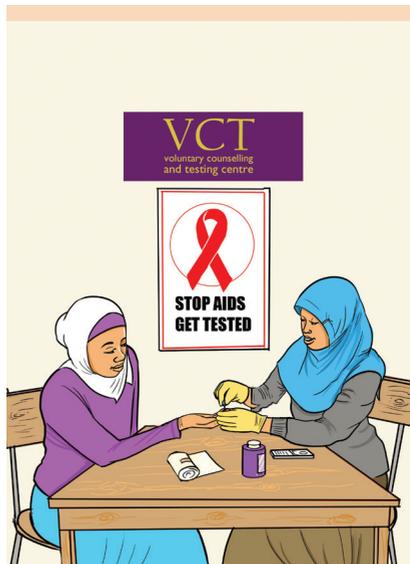
From the foregoing, it is clear that as believers and religious leaders, we must focus our attention on helping and supporting those among us who are in need. People living with HIV happen to be among them. We need to have the same attitude that Jesus had and take the initiative to have programs for care and support for PLHIV. This may include counseling.

Core principles of HIV and AIDS counseling for religious leaders

One person that people may easily turn to at the time of pain is a religious leader, who is very crucial when it comes to offering spiritual support. The following guide will enable you to provide counseling services and in particular to a person living with HIV (PLWHIV).

Before embarking on HIV counseling, religious leaders should be aware of the following legal and ethical considerations:

1. **Informed consent:** No one should be tested for HIV without consent. The law prescribes that children below 15 years must obtain the consent of parents or guardians in order to undergo testing. Further, a person cannot be forced to undergo a HIV test as a precondition for any rights (marriage, employment, association etc.)



No one should be tested for HIV without consent.

NOTE: As a religious leader, getting tested yourself will give you a chance to experience what a person goes through in making the decision to get tested and receiving the results of the test. It is also a way of leading by example (learn more about this from the World Council of Churches website).

2. Confidentiality/disclosure: There is need to always maintain confidentiality.

The religious leader should inform the client on the importance of disclosing their HIV status, unless circumstances exist that go beyond the limits of confidentiality e.g. where a person is aware of their HIV status and may infect his/her partner.

3. “Do no harm.” This involves:
 - Offering the services with dignity, respecting and promoting the welfare of PLHIV.
 - Responsibility: Maintaining maximum standards of care.
 - Establishing a relationship of trust.
 - Avoiding transference and counter transference (for example, no sexual relationships with people seeking counseling).
 - Treating people equally and fairly.
 - Avoiding conflict of interest.

Stages in HIV Counseling

The first stage of counseling involves welcoming of the client, introductions, and building rapport. How you handle this initial interaction will create trust and make the person feel at ease. From the very beginning, it is important to show acceptance and to skillfully attend to the person. Be especially careful of what you say at this point, as the individual may be very sensitive.

1. Welcoming and Introduction

Welcome the person warmly, with a handshake for instance, if it is culturally and religiously appropriate. Reassure the person that he or she is in the right place.



Greeting and introducing yourself is important on the first meeting.

After welcoming the person, introduce yourself (if the person does not know you) and allow the person to introduce themselves too.

Let the person know that you are pleased that they made the decision to come see you.

You may consider starting with a general prayer to put the person at ease or to break the ice.

2. *Clarification of Counseling Needs*

Considering that you offer different services, encourage the person to let you know what you can do for them. Once you establish that the person wants counseling, give him or her a brief about counseling.

At this point it is good to remember that the person who comes to you may be seeking some other information or service but that your knowledge of HIV and AIDS may be relevant. Consider the following scenarios:

SCENARIO 1 *Wedding*

Some religious leaders are legally registered marriage officers and they therefore officiate weddings. When a couple comes for such services, the religious leader may consider providing counseling information on a variety of life issues. This would be a good opportunity to encourage the couple to seek HIV counseling and testing. It is important to note, however, that it is illegal to force a person to undergo testing as a precondition for marriage.

It may be the case that some couples desiring to get married will come to the religious leader already aware that one of the partners is HIV positive and one is not; or both of them may be HIV positive. These are different situations that require different approaches in counseling.

SCENARIO 2 *Re-union*

There are instances when a couple may have been separated for a long time due to a variety of issues (travel, imprisonment, conflict, work). When opportunities come for re-union, the joy and anticipation may obscure other important considerations like HIV prevention. The religious leader providing support should help the couple avoid infection risk by helping them access prevention services as they undergo testing to ascertain their status.

SCENARIO 3 *Infidelity*

There are times when a person will approach the religious leader because of suspected or known sexual infidelity by their partner. Such cases need special sensitivity with respect to the advice and guidance given. The religious leader must take into account behavior that may have exposed the partner in question to infection and provide information that can reduce risk for the other partner.

SCENARIO 4 *Sexual Assault*

A person has come to see you because they or someone they know has experienced sexual assault. As you address the issues related to assault generally (conflict resolution, legal redress, safety and security), you will also need to assist the person to access certain HIV services, including testing and post-exposure prophylaxis.

SCENARIO 5

Non-sexual Exposure

You may learn that a client is at risk due to some type of non-sexual exposure. Most commonly, this would be from contact with some body fluids from an infected person. Subject to this risk are care-givers, people involved in accidents or assisting accident victims, and participants in outdoor activities that may lead to cuts and bruises, among others. Providing information on prevention, pre- and post-exposure prophylaxis, care and treatment, and HTS may be appropriate.

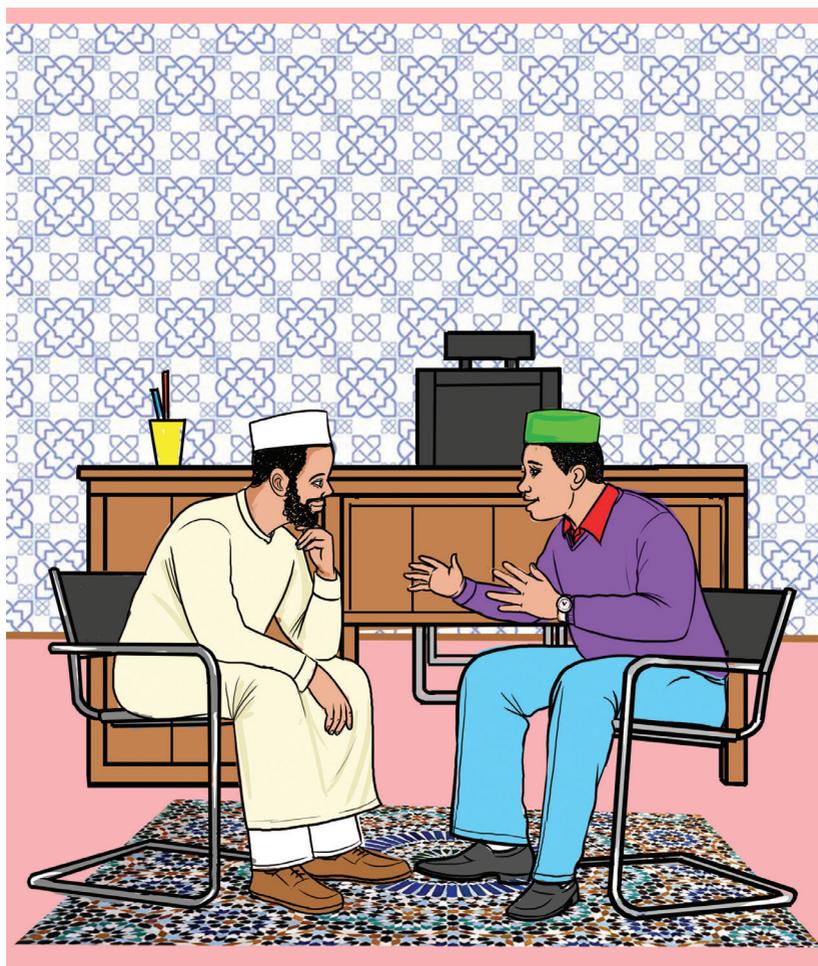
Besides these examples, there are scenarios that involve people who suspect or know that they have been exposed to or infected with HIV. Still others will come to the religious leader because they have partners or relatives who are infected or affected by HIV and AIDS. The religious leader should be aware and ready to deal with these scenarios.

3. The Counseling Process

a) Ensure that the counseling environment is comfortable enough for the person

For the person to feel more trusting of you, signal your attention as you listen with these attending behaviors captured by the acronym SOLER (Egan, 1994):

- S – Squarely:** this involves sitting and facing the person (with nothing in between).
- O – Open:** listen without crossing your feet or hands.
- L – Lean:** slightly forward.
- E – Eye:** establish and good eye contact; do not stare; be natural; don't let your eyes wander.
- R – Relax:** be yourself ; do not be tense or force the interaction.



REMEMBER: Receptiveness to counseling is encouraged by acceptance, respect, genuineness, positivity, commitment, clear interpersonal boundaries (without manipulation or meeting personal needs at the expense of the client's needs), immediacy (deal with the issues the person presents at the appropriate time), and sharing information that can potentially transform the person.

Receptiveness to counseling is discouraged by minimizing, invalidating and trivializing the person's issues, criticizing, moralizing or sermonizing, judging, overreacting, or discrimination (on the basis of age, ethnicity, racism, religion, culture, etc).

b) Explain to the client how counseling works

Counseling involves verbal communication and feedback (talk therapy). For counseling to work, both client and counselor have a role to play. The client talks, answers questions, and implements what is agreed. The counselor listens and helps the client explore the issue(s) with a focus on problem-solving, making informed decisions, acquiring or clarifying value(s), and making a change or adjustment in life, among other positive outcomes.

REMEMBER: For counseling to work, both client and counselor have a role to play. The client talks, answers questions, and implements what is agreed.

c) Allocation of time

Let the person know how much time you have for him/her, typically 60-90 minutes for the session; but assure the client you can schedule an additional session or sessions thereafter if needed.

d) Referral

Sometimes, a client's problem may be beyond your experience and expertise. In such cases, you should refer a client to someone else with the knowledge, skill, experience and expertise required. Before doing the referral, discuss with the client the need for it to ensure that they understand. It is important for you to establish a referral network within your community for various services that your clients may require. You can also develop a referral directory.

Always ensure that you track the referrals you have made to make sure that your clients receive the necessary services.

Some of the services for which you may refer a client include:

- HIV and AIDS care and treatment
- Substance abuse counseling
- Peer support groups for PLWHIV
- Legal support
- Gender based violence support
- Education support
- Mental health care

REMEMBER: To avoid causing harm, refer the client to an expert or professional in that field if it is something that you do not have the necessary knowledge and skills in.

e) Contract for consent and assure confidentiality

To assure the person of confidentiality and to allow him/her to consent to receiving counseling, consider signing an informed consent and confidentiality form. This is a legally binding document that assures the person that you are willing to protect their privacy and that you care about them. Let the person know that whatever they share will be kept confidential. It will not be disclosed to any other person unless with explicit written or other form of consent/permission from them.

Let the person also know that there are limits to this confidentiality agreement, however, if you have reason to believe the person plans to harm him/herself or others. Under no circumstances can you keep a “secret” that could lead to someone’s death. To break confidentiality in order to prevent loss of life is an expression of love, caring, and deep concern, and is the only ethical choice in a situation as serious as this.

Before you move to the next stage of counseling where you will allow the person to share their problem, ask them if they have any questions (“Please feel free before we begin to ask any questions you may have”) and address these before proceeding.

REMEMBER: You must first reassure the client of confidentiality. Also let him or her know the limits of the confidentiality.

f) Invite the person to tell you about their problem/issue/challenge

As the person shares their problem, remember your biggest duty is to listen. Listen, listen, listen. Be gentle, kind, and understanding. Again, allow the person to talk as much as he or she wants. Always listen very attentively, and encourage him or her to talk more. Be as gentle, kind, and understanding as possible.

Use *active listening* which involves:

- Allowing the person to fully and deeply describe their problem: This means that you will need good responding skills, so the person will feel accompanied and supported.
- Allowing the person to fully express themselves: Crying, for instance, is perfectly fine; it is part of processing pain and provides emotional relief. Offering tissue for wiping the tears shows acceptance and support.
- Observing the person as they talk and express themselves: Keep your focus on the person and not on your own problems or needs.
- Taking note of the person’s non-verbal communication or behavior: When you sense they are hesitant to discuss a particular topic, encourage them to go ahead (“It seems that is difficult for you; please feel free and share”) because that could be the real problem.

- As the person shares their story, you can ask appropriate questions for clarification.
- Once the person is done talking about the problem, explain that you will now summarize for them what you heard, so they can confirm if you understood correctly.
- Repeat by paraphrasing, summarizing, and pointing out the key thematic areas from the person's story

REMEMBER: Use active listening during the counseling process to ensure that you get not just the words of the client, but their non-verbal communication as well.

g) Help the person clarify issues

Help the person identify what their real problem is. Establish if the problem is as a result of:

- their personality and the way they relate with themselves (intrapersonal relationship)
- interactions with those they are in relationship with (family, marriage, friendship, or the community as a whole)
- unmet needs, choices they make, their motivation, or inability to use their full potential
- prior life experiences
- religious/spiritual influences (beliefs, values, attitudes, etc.)
- behavior, feelings or emotions
- cognitive constructs (how they perceive and interpret the issue/problem).

REMEMBER: It is of paramount importance that the client clarifies the problem at hand, only then can he or she begin to solve or deal with it.

h) Agree on solutions

Once you establish what is the real problem:

- Identify scriptures that will give the person comfort and guidance.
- Establish counseling goals and objectives based on your findings and what the person agrees to as the issues that he/she needs to work on during the counseling sessions.
- Agree on action to take, assigning tasks/action to be taken by the person when they get home and before the next counseling session.

REMEMBER: While prayer is important, it must be accompanied by taking medication, and living healthy. This is the only way to keep the viral load low and avoid opportunistic diseases. Be sure to warn the client against people who advise against medication to prove one's faith or spiritual healing.

i) Subsequent counseling sessions

Review the person's progress from the previous counseling session and work on the next issue based on counseling goals set earlier on.

j) Termination

Once all the counseling goals and objectives have been met and the person reports that they feel comfortable they can handle their situation, thank them for seeking help and for working on all that you agreed on and for making the progress in their lives.

k) Praying at the end of the counseling session

Consider offering a prayer. You might invite the client to pray first, if they would like to, and then you follow, thanking God for the healing or progress so far in the person's life and for the counseling relationship. Depart with God's blessing.





Handling HIV-related Disclosure



In some cases, a client may come to you out of fear that they may be infected. The first step to take in such a case is to ask the client if he or she has actually undertaken a HIV-test. If not, encourage the client to do so. Let the client know that this will be the first step in finding peace.

Once the client has undertaken the test and is found HIV negative, it is important to come up with a risk reduction plan, including retesting (see Annex 3).

When a person shares his or her positive HIV status with you, be aware that this can be an emotional moment. In such a situation do the following:

- a) Allow the person to fully express themselves.
- b) Assure them that there is nothing more important than their life, whatever the situation, and that you are glad they have made the choice to disclose to you.
- c) Inform the person that whenever someone receives painful information, they go through a grieving process, because they perceive they have lost something.
- d) Explain that it is normal to have the following feelings and reactions:
 - Hopelessness
 - Helplessness
 - Fear of abandonment

- Fear of rejection by family and friends
 - Diminished self-esteem
 - Stress
 - Anxiety
 - Guilt
 - Concern about being a burden to others
 - Depression
 - Suicidal (finds no reason for living)
- e) Probe to find their true feelings. You can do this by asking the following questions:
- How does this make you feel? (If the person cries, allow him/her to cry and encourage them to keep talking to you and let you know what comes to their mind.)
 - How has this changed your life? Or, What does this mean to you?
 - How will this affect your family, work, and life in general?
 - What have you thought of doing as a result of this diagnosis?
- f) Inform the person that an HIV positive diagnosis does not mean the end of life or that God does not care about the person. Let the person know the nature of God – especially when it comes to such a difficult moment – that God has **great compassion and love** for those who are in pain. (This is a starting point. You may want to say more about God’s love and acceptance.)
- g) Encourage them not to give up, but to work towards finding a balance by living positively with HIV.
- h) Encourage the person to be especially careful in selecting the people they tell about their status. They need to choose only those people whom they are confident can deal with crises.

They need to ask themselves, “Can this person realistically keep my news confidential for the period of time I need?” and make sure that they are comfortable in the company of those they tell about their status.

- i) Establish if the person went for further testing to establish their viral load and the status of their immune system. If not, emphasize the need for further testing and provide a referral where they can go for further testing.
- j) Emphasize the importance of treatment and adherence to treatment to help keep the viral load low and to boost the person’s immune system to avoid it being compromised by the virus.
- k) Let the person know that taking charge of their medical treatment is a major part of moving from the dread of diagnosis to empowerment over it. If possible, they will need to read more about HIV, take note of the treatment options given to them, and consult widely for informed decision-making about medical care.
- l) Emphasize physical exercise, nutrition, and self-care.

Annex 1

Dealing with Stigma and Discrimination

Stigma

Stigma is generally defined as an attitude that discredits or lowers one's perception of a person (in this case, one who is infected with HIV), judging that person to be abnormal or less worthy than others. There are also cases of "self stigma" where an HIV positive person sees himself or herself as being of lesser value. Those who are infected or affected by HIV may be socially labeled as "different" people, considered "them" instead of "us". Stigma results in general disapproval, rejection, exclusion and, in its worst form, discrimination or denial of access to essential services.

When the person is dealing with stigma, especially self-stigma, it is important to remind the person about God's love for them.

Discrimination refers to any distinction, exclusion or restriction (in this context, on the basis of a person's HIV status) intended to or with the effect of nullifying the recognition, enjoyment or exercise of any religious, social, business, or personal activities on an equal basis with others.

Inform the person that stigma and discrimination are rooted in ignorance. Let them know that they deserve to be treated with respect and sensitivity all the time. Establish if they have experienced any form of negative, hurtful statements from insensitive people.

Annex 2

Managing the Risk of Suicide

Assessing for the risk of suicide

Establish if the person has had suicidal thoughts or has attempted suicide. If so:

- Let the person know that suicide is not the answer, getting help is the answer. Let the person know that through counseling they will find hope, comfort, understanding, support and God's love. Show the person that their life is extremely valuable despite the infection and that God cares about him or her.
- Help them know that they are going through emotional pain and what they want to bring to an end is the pain and not their life. Help them see the difference between pain and life.
- Once you have calmed them down, ask them to sign a suicide prevention contract to prevent him or her from acting on his/her suicidal thoughts, and encourage the client to seek help in case they get overwhelmed by the suicidal thoughts.
- Only let the person leave the counseling session when you are sure that he or she is not in immediate danger of suicide.

Check on the client's social support system

Establish if the person has a support system from family, friends and other worshipers. Talking with others who are going through the same can help him/her to learn about the seemingly uncharted territory ahead of them. Give information about a good support system; a good support person is the kind of person who can help

both the client and the other people he/she will want to tell about their status.

The person needs to take the time to think through just what they need from others, then choose only to be with the people who meet their values and needs. Emphasize that joining a support group helps the person know that they are not alone. Let the person know that despite their condition, they are valuable and can make a difference in the society. With time, they will be in a position to help others who are experiencing similar conditions.

Help the person deal with fear and negative emotions. Encourage the client to replace thoughts like “I deserve to die for all the things I have done” with “I may have behaved in ways that damaged my health in the past, but I now have the time and desire to do things differently.” When he or she is overwhelmed by negative thoughts, ask them to try and recall the good things he or she has done. The client can also recall his or her potential and think of how that potential can be used to make other people’s lives better. The client should also take up healthy activities that they enjoy, like going for a movie, walking in the park, even just taking a hot bath.

Talk about hope

Hope in the face of a difficult diagnosis is not denial. To many people, hope can be a source of strength even in a seemingly hopeless situation if it is based on the religious faith and the grace of God. There are many ways for active faith to restore hope. Encourage the client to live purposefully, focusing on important goals or milestones they want to achieve, for example “as a parent I will live to see my children graduate.”

Organize for ongoing counseling support

Let the person know that after this initial counseling session, you will be available to help him or her work through all of the issues that are bothering him/her. Tell them that healing and managing the changes brought by the diagnosis is a process that requires one to go step by step. Reassure the person that with time and by taking the necessary action, they will be able to adjust and live their life fully.

Annex 3

Recommendations for Retesting HIV Negative Clients

Scenario/Population	Recommendation for Retesting
General population	Retest at least annually (for children, re-testing is only required if there is a new exposure)
Key populations (PWID, SW, MSM)	Retest every 3 months in case of frequent instances of high risk exposure
Negative partner in discordant union	Re-test every 3 months until HIV-positive partner achieves viral suppression. Once viral suppression is confirmed retesting can be performed every 6 months. Other prevention services should still be recommended, including consistent and correct use of condoms. Assess for eligibility and willingness for PrEP
Pregnant women	All pregnant women should be retested in the third trimester. At labor and delivery, HIV testing should be done for all women with unknown HIV status and previously tested negative (even if tested negative in third trimester)
Breastfeeding mothers	Retest after delivery at the 6 week infant immunization visit, and then every 6 months until complete cessation of breastfeeding
HIV exposed infants	All HEI should have DNA PCR testing at 6 weeks, 6 months, and 12 months, and then HIV antibody testing at 18 months and then every 6 months thereafter if they continue breastfeeding. All HEI should have HIV antibody testing 6 weeks after complete cessation of breastfeeding
Persons who had a recent (e.g. less than a month) specific exposure incidence	Test at initial presentation and retest at 12 weeks and then as per risk group
Patients with a confirmed or suspected STI	Test at initial presentation and retest at 12 weeks and then as per risk group
Individuals on pre-exposure Prophylaxis (PrEP)	Retest every 3 months

Source: Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya (NASCOP, 2018)

Annex 4

Client Information

WHAT IS INFORMED CONSENT?

Informed consent generally means the client has the capacity to consent, has been adequately informed concerning the process and procedure of counseling, and has freely, without influence, expressed and provided consent.

DESCRIPTION OF RELIGIOUS COUNSELING

The goal of religious counseling is to help an individual think religiously about their current struggles in the context of a confidential, caring environment. A religious leader relies on scripture as the sole authority for faith and conduct, and recognizes that lasting change is the result of the power of God. Guided by scriptural principles, the religious leader's role is to utilize guided questioning, empathetic support, problem definition, reflection/reading assignments, encouragement, and prayer to provide wise, scriptural and faithful counsel to those who are hurting and in need.

REFERRAL POLICY/DISCLAIMER

After assessment, determine whether or not you can provide the appropriate services and level of care needed. Refer clients to specialists if the help required is beyond the scope of care that you can give.

RELIGIOUS COUNSELING SESSIONS —○

Inform the client how long the counseling sessions will be, where they will be held, and any charges that they may incur.

CLIENT EXPECTATIONS —○

Let the client know that prayer and scripture reading may be utilized as part of the counseling process. Inform them that their commitment to the counseling process will greatly determine the outcome of their experience.

CONFIDENTIALITY —○

Inform the client that you will adhere to commonly accepted codes of privacy and confidentiality in counseling ethics. There are situations, however, in which the law allows for certain information to be revealed without the client's consent. Under your discretion, if there is any indication that the client may be a danger to himself/herself or others, or are involved in the abuse of a minor; you may disclose their information to appropriate health services or law enforcement. Also, let the client know that if deemed appropriate, you may decide that another religious leader or counselor be consulted to ensure the continuity of quality of care they are receiving.

RIGHTS AS A CLIENT —○

Inform the client that they:

1. are entitled to information about any procedures, methods of counseling, techniques and possible duration of therapy.
2. have the right to end counseling at any time without any moral, legal or financial obligations other than those already accrued.

3. have the right to expect confidentiality within the limits described.
4. have the right to authorize you to consult with another professional about their therapy in writing.

MEDIATION AND ARBITRATION

Disputes arising out of or in relation to the agreement to provide services should first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator should be a neutral third party chosen by agreement of the client and yourself. The cost of such mediation, if any, shall be split equally.

CANCELLATION POLICY

Request the client to notify you at least 24 hours before their scheduled appointment time if they need to cancel a session. Exceptions are for sudden illnesses and emergencies only.

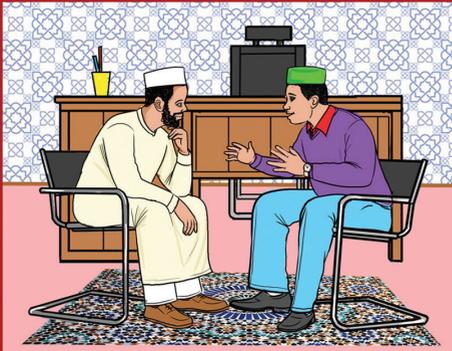
CONTACTING THE PASTORAL/ RELIGIOUS COUNSELOR

Provide the client with email, telephone and any other contact information they can use to get in touch.



HIV & AIDS

COUNSELING GUIDE FOR RELIGIOUS LEADERS



Religious leaders are strategically positioned for HIV and AIDS counseling due to their unique position in society. Their leadership and counsel is recognized and highly valued. They enjoy a high level of trust by the community, and they are close to the people, especially in times of crisis. The level of receptivity is high during such times and therefore conducive for information sharing and emotional support.

This **HIV & AIDS Counseling Guide for Religious Leaders** aims at guiding religious leaders as they provide support to congregants and others who approach them for help to cope with HIV and AIDS issues.

The guide:

- Considers the full spectrum of client needs – physical, psychological and socio-economic.
- Appreciates the role of ongoing support, including information to help avoid transmission to others.
- Recognizes the place of science in HIV and AIDS and the use of religious tools that people ascribe to to provide support.
- Respects individual religious convictions and beliefs of people seeking counseling.

ISBN 978-9966-820-09-9



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