COUNSELING FOR
HIV/AIDS

The National Guidelines

National AIDS Control Programme
National Institute of Health
Islamabad

Joint UN Programme on HIV/AIDS
(UNAIDS) Pakistan
PREFACE

Ever since the beginning of AIDS epidemic in 1981, the number of people infected and affected by HIV/AIDS is on the rise. During the course of infection, a broad range of physical, social and psychological needs and problems is experienced. Changing nature of the illness imposes a variety of psychological and emotional strains on individuals and those closest to them. Taking into account the dilemmas associated with it, the effects of HIV epidemic are enormous. AIDS, in fact, is seen more as a psychosocial phenomenon than a disease.

HIV/AIDS counselling assists people to make informed decisions, cope better with their condition, lead more positive lives, and prevent HIV transmission. HIV/AIDS counselling is important because infection with HIV is life long. Role of counselling in HIV/AIDS is perhaps more important than in any other disease.

Existence of standard guidelines for the people involved in HIV/AIDS prevention and control activities ensures that all efforts being made for the purpose are well coordinated and in right direction. Moreover, it is important to have guidelines written in the context of one’s own culture, financial and resource constraints and prevailing socio-medical standards. Counselling is actually a highly specialized field and very little is available in Pakistan on the subject, particularly in the context of HIV/AIDS. The in hand knowledge is, therefore, required to be regularly updated and disseminated to those who are in need of it.

Keeping this in view and for a systematic dissemination of the available knowledge to the concerned professionals, National AIDS Control Programme (NACP) and Joint United Nations Programme on HIV/AIDS (UNAIDS) Pakistan decided to develop national guidelines on Counselling for HIV/AIDS. These guidelines have been developed and reviewed by renowned practicing experts in their work field.

Purpose of the counselling guidelines is to provide an in-depth knowledge on the subject to the clinicians, laboratory professionals, psychiatrists and the social workers, both in the public as well as private sectors, that would help them to manage HIV/AIDS and prevent its further spread.

The guidelines describe the role and mechanism of counselling in different circumstances that are likely to be experienced by the people involved in AIDS prevention activities in one way or the other. The readers desirous of detailed information may consult the guidelines on Clinical Management and HIV Antibody Testing developed by the NACP and UNAIDS Pakistan.

Although a great effort has been put in to ensure a really useful and practicable manuscript yet there would be ample space for improvement, since the exercise has been carried out for the first time in Pakistan. Any suggestion, guidance and critique from the working specialists would be warmly welcome as it remains the main tool to enhance the quality of this manuscript in the years to come.

(Dr. Athar Saeed Dil)
Executive Director & National Coordinator
August, 2001
ACKNOWLEDGEMENTS

The National AIDS Control Programme and UNAIDS Pakistan gratefully acknowledge the work done by Dr. Elizabeth Lindsey, a short term WHO Consultant who developed the basic format of these guidelines. Contributions of Dr. Aftab Asif, the co-author, are also highly appreciated who did the laborious work of adaptation in context of the prevailing socio-economic norms in Pakistan. Similarly, the inputs from the experts, listed at annexures I & II, involved in review, consensus building and pre-testing work are also gratefully acknowledged.

The Provincial AIDS Control Programmes actively participated in the development process of these guidelines for which the NACP and UNAIDS are greatly indebted. Dr. Rana Muhammad Safdar, Dr. Najma Lalji, Dr. Hassan Ooroj, Dr. Asma Bokhari and Dr. Aysha Asad of the NACP/UNAIDS managed all basic work, arranged workshops and rendered most valuable services for the development and publishing of the guidelines. Their hard work and useful inputs are acknowledged and endorsed with great pleasure.

The Programme is indebted for the organizational assistance of UNAIDS Pakistan Secretariat, Islamabad. The continuous support, professional inputs and great deal of personal interest and guidance by Dr. Kristan K. Schoultz, Country Programme Advisor UNAIDS Pakistan has been beyond measure throughout the process.

The National AIDS Control Programme owes a lot and is thankful to the Federal Secretary Health, Director General Health and the Executive Director NIH for their kind patronage. Their guidance, continuous support and encouragement for the Programme are most sincerely acknowledged.

(Dr. Birjees Mazher Kazi)
National Programme Manager
August, 2001
# CONTENTS

## CHAPTER 1: INTRODUCTION

- Global Situation .......................................................... 1
- HIV/AIDS in Pakistan ................................................. 1
- What is HIV/AIDS? .................................................... 1
- HIV Transmission ......................................................... 2
- Natural History of HIV Infection ..................................... 2

## CHAPTER 2: THE PURPOSE OF COUNSELLING

- Rationale for HIV Counselling ........................................ 4
- Who Should Become HIV Counsellors? ............................ 5
- Who Should Receive HIV Counselling? .............................. 5
- Where Should HIV Counselling Take Place? ....................... 5
- Confidentiality and Informed Consent .............................. 6

## CHAPTER 3: BARRIERS TO EFFECTIVE HIV COUNSELLING

- Strategies to Confront Biases, Beliefs, Values and Assumptions 7
- Culture and Tradition ................................................... 7

## CHAPTER 4: PSYCHOSOCIAL ASPECTS OF HIV COUNSELLING

- Psychological Stress of HIV/AIDS .................................. 10
- Shock ........................................................................... 10
- Denial .......................................................................... 10
- Anger ........................................................................... 10
- Fear ............................................................................. 11
- Isolation ........................................................................ 11
- Loss ............................................................................ 11
- Grief ............................................................................ 11
- Guilt ............................................................................. 12
- Depression ................................................................. 12
- Anxiety ......................................................................... 12
- Loss of Self Esteem ...................................................... 12
- Suicidal Thought and Actions ......................................... 12
- Hypochondria .............................................................. 13
- Spiritual Concerns ....................................................... 13
- Additional Complications ............................................. 13
CHAPTER 5: COUNSELLING SKILLS AND RESOURCES

- Stages of the Counselling Relationship
- Effective Interpersonal Communication Skills
- Common Errors in Counselling
- Non-verbal Communication
- Introducing Sensitive Topics
- Crisis Counselling
- Problem-solving Counselling
- Decision-making Counselling
- Developing Adequate Resource Networks
- Self-help Peer Groups

CHAPTER 6: VOLUNTARY HIV TESTING AND COUNSELLING (VCT)

- Antibody Testing
  - Antibody Tests
  - False positive test results
  - False negative test results
- Pre-test Counselling
  - Components of pre-test counselling
  - Benefits of pre-test counselling
- Post-test Counselling
  - HIV-positive test result counselling
  - HIV-negative test result counselling
- Counselling after an equivocal test, or a positive first test when a second test should be performed
- Continued Counselling and Support
  - Bereavement Counselling

CHAPTER 7: COUNSELLING AND EDUCATION

- Behavioural Change
- The use of Condoms
  - Male condom
  - Female condom
  - Other barrier methods
- Injecting Drug Users and Other Mood Altering Drugs
  - Promoting use of sterile equipment
  - Harm reduction
  - Other mood altering drugs
- Blood Safety
  - Minimizing the risk of HIV-infected Blood Transfusions
  - Selecting blood donors
  - Benefits of VCT in blood testing services
CHAPTER 8: POPULATIONS WITH SPECIAL NEEDS

The Vulnerability of Women
- Biological vulnerability
- Social and economic vulnerability
- Traditional norms and values
- Lack of education
- Sexual customs & norms
- Lack of economic opportunities
- Lack of control in relationships
- STDs and HIV
- HIV and prostitution

The Counsellor's Role in Fostering Empowerment
- Combating ignorance
- Ensuring women have access to appropriate care
- Building safer cultural norms
- Reinforcing women's economic independence

Mother to Child Transmission
Counselling Women
Couple and Family Counselling

CHAPTER 9: STRATEGIES TO INTRODUCE AND SUPPORT HIV COUNSELLING SERVICES

Elements for Effective VCT Services
Care for the Caregiver

LIST OF TABLES

Table 1: HIV Pre-test Counselling Checklist
Table 2: HIV Post-test Counselling Checklist-positive result
Table 3: HIV Post-test Counselling Checklist-negative result
Table 4: HIV Counselling Checklist in Pregnancy

LIST OF FIGURES

Figure 1: Structure of the Counselling Process
Figure 2: Pre-test and Post-test Voluntary Testing and Counselling
Figure 3: HIV Counselling Positive Test Result
Figure 4: Post-Test Counselling- Negative Result
Figure 5: Requesting Second Test or Equivocal Result
Figure 6: Flow Chart of stages in Blood Donor Counselling

APPENDICES

Appendix A: HIV Antibody Consent Form
Appendix B: Suggested Open-Ended Questions HIV Counselling
Appendix C: Pre-test Counselling Visit 52
Appendix D: Post-test Counselling Visit 53
Appendix E: Partner Notification Form 54
Appendix F: Patient Information Sheets 55

**ANNEXURES**

ANNEX -I  Participants of the consensus Building workshop for the "Guidelines on Counseling for HIV/AIDS" 59
ANNEX-II  Participants of the workshops to pre-test the "Guidelines on Counselling for HIV/AIDS" 60
ANNEX-III  List of the HIV/AIDS surveillance Centres 60
INTRODUCTION

GLOBAL SITUATION OF HIV/AIDS:

Spread of HIV and development of AIDS are being closely monitored worldwide. UNAIDS and WHO estimate that the number of people living with HIV/AIDS at the end of the year 2000 stands at 36.1 million including 16.4 million women. This is 50% higher than what WHO's global programme on AIDS projected in 1991 on the basis of available data at that time. 5.3 million persons were newly infected with HIV while 3 million deaths occurred due to AIDS during the year 2000, bringing the total death toll to 21.8 million since the beginning of the epidemic.

Recent evidence affirms that the disease is spreading in Asia faster than anywhere else in the world and perhaps as fast as it did in Africa, a decade ago. An estimated 700,000 adults, 450,000 of them men, have become infected in south and south-east Asia in the course of the year 2000. Overall, as of end 2000, the region is estimated to have 5.8 million adults and children living with HIV/AIDS

HIV/AIDS IN PAKISTAN:

Since the official recognition of the first case in 1987, the number of officially reported HIV infections and AIDS cases has grown to 1787 (as of March 2001). Unfortunately, most observers believe that the number of reported cases represents only the "tip of the iceberg", and that the number of actual cases may be far greater. Although the exact figures are not available at the moment, according to the WHO/UNAIDS forecast model, currently there are estimated 60,000 to 74,000 HIV infected individuals. However, a study is underway to ascertain the number of STD cases in each province, and these figures can be extrapolated to provide a more realistic figure of the true picture of AIDS in Pakistan. Because the greatest form of HIV transmission is through sexual contact, these STD figures will provide some insight into the number of people who could be potentially susceptible to HIV.

The groups at increased risk of acquiring the HIV infection have been defined in Pakistan and are the persons with risky behaviour, blood and blood product recipients, IV drug addicts, STD patients, professional blood donors and seamen. There are more than three million nationals working abroad with their families based in Pakistan. A large number of immigrants especially from Afghanistan and international tourists come to visit Pakistan. There is low literacy rate among the general public with insufficient awareness regarding HIV/AIDS transmission.

Compared to many parts of the world, Pakistan is in a fortunate position in having small numbers of HIV infected people. However, experience has shown that if HIV is not controlled, these figures will rise rapidly, and a full epidemic could result. From experience with other countries in the world, it has been found that HIV counselling is one of the most important and effective interventions in HIV prevention and care. Not only does effective HIV counselling promote behavioural change and risk reduction activities, but counselling also provides people living with HIV/AIDS a better quality of life, and to experience a more peaceful death.

What is HIV and AIDS?

In 1983, scientists in France discovered the virus that causes AIDS and routes of its transmission were confirmed. The virus eventually became known as the human immunodeficiency virus (HIV). There are 2 different types of HIV, which cause AIDS: (a) HIV-1, the most common type found worldwide, and (b) HIV-2 found mostly in West Africa.

HIV infection affects the immune system resulting in its weakness called
immunodeficiency. Immune system provides the body’s defence against the micro-organisms (such as bacteria, viruses, fungi etc) that penetrate the skin and mucous membranes and cause disease. In a healthy person, the immune system produces antibodies to fight off or kill these micro-organisms thereby preventing the occurrence of disease. In an immuno-deficient individual this ability to combat disease causing germs is lost by the following mechanism:

Human immunodeficiency virus (HIV) infects and eventually destroys the lymphocytes and monocytes of the immune system. These cells carry the CD4 antigen on their surface (CD4+ lymphocytes). HIV having special affinity for the CD4 antigen enters and infects CD4+ lymphocytes resulting in killing of many CD4+ lymphocytes. This slowly leads to a persistent, progressive and profound impairment of the immune system, making an individual susceptible to opportunistic infections and conditions such as cancer.

HIV is the beginning stage of infection. The person remains symptomless and HIV antibodies can be detected only by a blood test. The infection gradually progresses to AIDS when the immune system becomes very affected resulting in appearance of certain opportunistic infections and cancers.

**HIV TRANSMISSION**

There are many myths and misunderstandings about the mode of transmission of HIV. It is very important for a counsellor to understand the modes of transmission so that effective HIV counselling can take place. HIV can be transmitted by:

a) Sexual intercourse (vaginal, anal and oral) or through contact with infected blood, semen, or cervical and vaginal fluids. This is the most frequent mode of transmission and HIV can be transmitted from any infected person to his or her sexual partner; man to woman, woman to man, man to man, and (but less likely) woman to woman. Other sexually transmitted diseases (STDs) (especially those causing genital ulcers) increase the risk of HIV transmission because more mucous membrane is exposed to the virus.

b) Transfusion of blood or blood products obtained from an infected donor.

c) Injecting or skin-piercing equipment contaminated with HIV.

d) Mother to infant during pregnancy, labour, or as a result of breast feeding.

**HIV cannot be transmitted by the routine contact/activities such as:**

(a) Coughing or sneezing
(b) Handshakes
(c) Insect bites
(d) Work or school contact
(e) Touching or hugging
(f) Using toilets
(g) Water or food
(h) Using telephones
(i) Kissing
(j) Swimming pools
(k) Public baths
(l) Sharing cups, glasses, plates and other eating and drinking utensils.

**Natural History of HIV Infection:**

Natural history of HIV/AIDS can be studied under following phases:

(a) **Acute HIV Infection:**

Most people infected with HIV do not know that they have become infected. Antibodies to HIV antigens are usually developed 6 weeks to 3 months after being infected. In some individuals, the test may not be positive until 6 months or longer (although this would be considered unusual). This time is known as the “the window period” during which the person can be highly infectious and yet unaware of their condition. The term sero-
conversion is used when a person recently infected with HIV tests sero-positive for HIV antibodies.

(b) HIV Infection before the onset of symptoms

In adults, there is often a long, silent period of HIV infection before the disease progresses to full blown AIDS. A person infected with HIV may have no symptoms for up to 10 years or more. The vast majority of HIV-infected children are infected in the peri-natal period (during pregnancy and childbirth). The period without symptoms is shorter in children, with a few infants becoming ill in the first few weeks of life.

(c) Progression from HIV infection to HIV-related disease and AIDS

Almost all (if not all) HIV-infected people will ultimately develop HIV-related disease and AIDS. This progression depends on the type and strain of the virus and certain host characteristics. Factors that may cause faster progression include age less than 5 years, or over 40 years, other infections and possibly genetic (hereditary) factors. HIV infects both the central and the peripheral nervous system early in the course of infection. This causes a variety of neurological and neuro-psychiatric conditions. As HIV infection progresses and the person's immunity declines, people become more susceptible to opportunistic infections and cancers. These include: Tuberculosis, sexually transmitted diseases, septicaemia, pneumonia (usually pneumocystis carinii), recurrent fungal infections of the skin, mouth and throat, other skin diseases, unexplained fever, unexplained weight loss (also known as AIDS-related complex ARC), chronic diarrhoea with weight loss (often known as "slim disease"), meningitis, other diseases such as cancers (e.g. Kaposi sarcoma).
THE PURPOSE OF COUNSELLING

Rationale for HIV Counselling:

Various studies throughout the world suggest that HIV/AIDS counselling assists people to make informed decisions, cope better with their condition, lead more positive lives, and prevent HIV transmission. HIV/AIDS counselling is important because infection with HIV is a life long phenomenon and during the course of the infection, a broad range of physical, social and psychological needs and problems are likely to be experienced. The changing nature of the illness imposes a variety of psychological and emotional strains on individuals and those closest to them.

HIV/AIDS counselling is a dialogue between a client and a care provider aimed at enabling the client to cope with stress and to make personal decisions related to HIV/AIDS. The counselling process includes the evaluation of personal risk of HIV transmission and the facilitation of preventive behaviour.

HIV/AIDS counselling is a process that begins with the client's first contact either with an HIV/AIDS counselling service or with the care system for HIV-related needs. In the context of HIV/AIDS, the care system includes all health and social service facilities, both governmental and non-governmental, where individuals receive care and social support. The counselling process continues through a referral network to various community and social support agencies, according to the need of the individual and the family affected by or worried about HIV.

Main goals of counselling are:

1. To provide psychosocial support to those whose lives have been affected by HIV

2. To prevent HIV infection and its transmission to other people.

There are two major elements of counselling for HIV/AIDS:

- The formation of sensitive, trusting and respectful relationships; and
- A structured approach to ensure the client has adequate knowledge for problem-solving and decision making in pre and post-test counselling.

The overall purposes of HIV counselling are:

- To provide clients with information on HIV/AIDS (e.g. means of transmission, prevention, testing etc),
- To help the infected individual, family and friends to handle possible emotional reactions to HIV/AIDS (e.g. grief, anger, fear, denial),
- To discuss courses of action adapted to client/family needs and circumstances,
- To encourage change, when needed, for the prevention or control of infection (e.g. through protected or safer sex, and changes to drug injecting practices)
- To assess the risk of HIV infection in potential blood and organ donors.

Counselling helps people to define for themselves the nature of the problems they are facing. They can then make realistic decisions about what they can do to reduce the impact of these problems on themselves, their family and friends. Helping people to achieve the confidence to make lifestyle changes is an integral
part of the counselling relationship. Effective counselling should occur where people most need it and should not be restricted to a clinic or a structured doctor-patient situation.

Who Should Become HIV Counsellors?

A wide range of people can play a role in the provision of HIV/AIDS counselling. These people include:

- Doctors, nurses, community health workers, social workers, and other care-providers who have been specially trained in HIV/AIDS counselling. Some of these trained individuals may also act as "focal points" and educators for counselling services in their province, district, or community;

- Full-time counsellors (e.g. psychologists, psychiatrists, and therapists) who have been trained in HIV/AIDS counselling, and who may receive clients directly, or who may receive clients through referral by other care-providers;

- Religious leaders and other community-based workers who work consistently with people in confidential situations and with emotional concerns;

- Trained community members, members of AIDS support groups, and other people living with HIV/AIDS.

The people who are respected by the community, engender a sense of trust and respect with the people with whom they are working, and are willing to receive the specialized counselling training are the ideal selection to become HIV/AIDS counsellors.

Who should receive HIV Counselling?

HIV/AIDS counselling is for individuals, couples, families and groups. In particular, HIV counselling is for

- People who are worried about their HIV status, and request testing for HIV (pre-test, and post test counselling);

- Those having HIV/AIDS in their families;

- People experiencing difficulties with issues such as stigma, isolation, financial hardships, as a result of HIV infection;

- Those seeking help because of past or current risk behaviours; and

- Those wishing to donate blood or body organs.

In Pakistan, where couples are monogamous, with no extra marital or pre marital sexual contact, the risk of HIV is negligible. However, any unprotected sexual contact outside this monogamous relationship carries a risk of HIV transmission. In any society, a variety of individuals and groups may be particularly at risk for HIV transmission. Some of these include:

- Men and women with multiple sex partners practising unprotected penetrative anal, vaginal and oral sex, including female and male commercial sex workers and their clients;

- Injecting drug users who share injecting equipment;

- Recipients of unsafe blood, blood products and donated organs

People in certain occupations are known to be at greater risk for HIV transmission
in Pakistan. These occupations include long haul lorry drivers, men who are working and are then deported from the Middle East, and "singing and dancing" girls (commercial sex workers).

Counselling is also needed for people who are at risk for HIV infection, and who do not know their HIV status. Some people may already recognize that they are at risk, while others will be unaware of the risk involved in their behaviours. Therefore, HIV education for the general population is an important strategy.

**Where Should HIV Counselling Take Place?**

HIV/AIDS counselling should take place wherever people concerned about, or living with HIV/AIDS live or are treated. Such places might include community health centres, rural health clinics, basic health units, hospitals, STD clinics, mother and child health clinics, reproductive health clinics, blood donation sites, antenatal and post partum clinics, schools, mosques, outpatient clinics, and all health outreach and community based programmes. Even in countries like Pakistan, where the incidence and prevalence of HIV is still comparatively low, counselling services should always be available at sites where care is being provided for HIV-positive people, voluntary counselling and testing centres and other sites where HIV tests are done and results can be traced to the individual, such as blood donation sites. Each site will influence how the counselling will be conducted and will require different responses from the counsellor. For example, it is much easier to counsel effectively when a private room is available, instead of trying to discuss sensitive matters in a busy and crowded clinic.

**Confidentiality and Informed Consent**

HIV/AIDS counselling sessions are confidential and most involve the participation of a single client and a single care-provider. The client has an absolute right to confidentiality and/or anonymity unless and until the client decides otherwise. However, at the discretion of the client and the care-provider, the following people may also be involved in HIV/AIDS counselling sessions:

- Members of the client's family;
- A second care-provider with additional counselling skills that may be required to help the client address a particular problem or sensitive issue;
- Members of a support group of individuals affected by or infected with HIV/AIDS;
- Other resource persons such as clinicians and other health and social service providers.

Although confidentiality is essential, it is important to encourage the client to share his/her test result with other supportive people. Research and experience has shown that people who share their diagnosis with others live a better quality of life, live longer, and experience a more peaceful death. However, because HIV/AIDS is surrounded by fear, stigma and isolation, people tend to fear disclosure of their condition. With support from the counsellor, and careful consideration of those who will share the client's confidence, the benefits of shared confidentiality far outweigh the risks.

To ensure confidentiality of client's records, the client's initials and date of birth can be the only identifying feature on the record. A second list containing information relating to the client can be kept in a separate place. This second list will contain tracing information to the initialled record. Only those care providers who are working directly with the client should have access to this second list.

Informed consent implies that the client fully understands the test that will be performed and the possible consequences.
of the test result (either positive or negative). This informed consent also involves the client's awareness of the window period, where the client may be infected, but still undetectable on testing (see Appendix A for a sample informed consent form).

In Pakistan, informed consent is implied when pretest counselling is completed and the client requested for the HIV test. However, it should be noted that the client may undergo HIV testing without pre-test counselling, but whenever possible, pre-test counselling should be encouraged and undertaken.
BARRIERS TO EFFECTIVE HIV COUNSELLING

HIV/AIDS is a condition that often generates fear, misunderstanding and discrimination. Misunderstandings are created by inaccurate or insufficient knowledge related to HIV and fear of contracting the disease. This discrimination and isolation can be exacerbated by emotional, cultural, sexual and religious influences.

Counsellors and other care-providers are not immune to acts of discrimination, and marginalisation of people living with HIV/AIDS (PLHA). This discrimination might arise from fear on contracting HIV while providing physical care for the PLHA (universal precautions must always be maintained). In addition, many care providers find it difficult to openly discuss sexual practices and preferences, sexual desires, and the number and type of sexual partners. There is often a "cloak of silence" related sexual practices and to illicit drug use. This is particularly relevant if these practices appear to by against the culture, traditions, laws and religions of Pakistan. Traditionally women cannot discuss sexual practices with men, or men with women. Consequently, care must be taken to select men to counsel men and women to counsel women. Intravenous drug use is another topic that many care-providers find difficult to discuss. In Pakistan the use of condoms as a method of birth control (as well as control of HIV transmission) is not openly discussed. In conclusion, experiences of fear, stigma, isolation, discrimination and marginalisation related to HIV/AIDS come from:

- Misinformation about HIV transmission
- Fear of contracting HIV
- Cultural influences related to sexuality and birth control
- Cultural norms of silence regarding sexual practices, preferences and desires.
- Legal issues related to the misuse of legal and illegal substances, particularly intravenous drug use (IVDU).

Negative attitudes, beliefs and values, or misinformation about HIV significantly affect the counsellor's ability to provide effective, respectful and dignified care. Some documented behaviours of care-providers include:

- Condemning the PLHA (i.e, considering the PLHA is a bad person);
- Isolating/avoiding the PLHA because of embarrassment of not knowing how to handle the situation;
- Refusing to treat/care for the PLHA or their families
- The inability to discuss sexual practices, preferences and desires because of embarrassment;
- Ignoring or avoiding discussion and counselling about risk behaviours and HIV prevention and care;
- Inability or unwillingness to approach the PLHA and family in a non-judgmental, caring and supportive manner.

Strategies to Confront Biases, Beliefs, Values and Assumptions

Self-Awareness: Counsellors must examine their own beliefs, values, assumptions and attitudes toward HIV/AIDS. There has been considerable evidence to suggest that care-providers are some of the worst offenders in discriminating against, and refusing to care for PLHA. Such practice is unacceptable, however, change will only come about if counsellors explore and challenge their negative thoughts, feelings and behaviours. This can
Counselling for HIV/AIDS 16

be done individually or through peer group support where feelings and attitudes can be discussed, explored and challenged. Counsellors do not have to like all their clients but should be keenly aware of how their feelings, attitudes and prejudices can negatively affect the counselling relationship. If a serious conflict arises, the client should, if possible, be transferred to another counsellor. In order to examine their own needs and motivations, counsellors should ask themselves the following questions:

- What are my own feelings about people with HIV/AIDS?
- What are my feelings about people whose behaviour has placed others (or themselves) at risk of infection?
- Are there some kinds of people or types of behaviour of which I disapprove so strongly that I probably could not counsel them non-judgementally?
- Am I trying to impose my own values on my clients? How much do I want to influence and control them?
- To what extent am I willing to let clients do what they decide to do and take responsibility for their own lives?

**Education:** The irrational and often exaggerated perceptions of fear associated with HIV/AIDS could be addressed through educational programmes based on sound medical, social and psychological knowledge. To be successful, educational programmes should be sustained over a period of time and not be episodic or developed in isolation. Knowledge about HIV/AIDS is constantly changing and counsellors must be updated through continuing education programmes. Counsellors can make an important contribution to educating others.

**Prevention:** Prevention strategies will continue to be compromised if fear, ignorance, intolerance, and discrimination against HIV infected persons persists. Where cultural norms and traditions conflict with HIV prevention and education strategies, these norms and traditions must be challenged.

**Culture and Tradition**

Encouraging and motivating clients to make decisions about changing their risk behaviours or lifestyles are important counselling strategies. Clients are more likely to make behavioural changes if the counsellor appreciates the cultural or traditional importance of the behaviour. "Culture" can be defined as the habits, expectations, behaviours, rituals, values and beliefs that people develop over time. In this sense, culture is a product of the interaction between people, ideas and the physical environment. Through culture and tradition, people learn acceptable behaviour, and what is considered right and wrong.

Culture strongly influences people's feeling and beliefs about health and illness, about caring for the sick and about death and loss. Traditions handed down from one generation to another may be particularly important during times of stress, especially illness and death. One culture may see HIV/AIDS as a punishment while another culture may see it as fate. Therefore, culture and tradition will influence how people interpret, explain and respond to HIV/AIDS. Within Pakistan there will be variations on these cultural beliefs.

It is important for the counsellor to examine his/her own cultural beliefs and values and to assess whether they are likely to be consistent with or opposed to the people they will counsel. If their cultural norms and traditions contradict, the counsellor must question whether he/she is able to transcend these cultural and traditional values to help the client. For example, the counsellor should question:
• Can I openly discuss issues of heterosexuality, homosexuality, and bisexuality?
• Can I counsel a commercial sex worker without prejudice?
• Can I discuss and demonstrate condom use?
• Can I counsel transvestites and other trans-sexual people?
• Can I counsel injecting drug users?

It should be noted that some cultural norms and practices should also be honoured. For example, it would be advisable for women to counsel women, and for men to counsel men. Also, if people feel they cannot overcome some of the issues raised in the above questions, they should feel comfortable to make this known to others. Other counsellors can then be asked to work with clients with particular risk behaviours.

Within Pakistan, there will be differing cultural beliefs and values. To gain a better understanding of the issues related to illness, HIV infection and counselling, the following questions can be asked:

• What do people believe causes illness, and how do they explain illness and death?

• What do people call HIV/AIDS (slang) and what do they believe causes it?

• What do people think about HIV-infected people? Are they blamed for their illness? If so, would they be abandoned?

• Who are recognised as helpers and healers? What types of treatment do they provide?

• What role do religious leaders play for people with HIV/AIDS?

• What is expected of people with regard to caring for the sick? Is the family expected to provide care?

• How do people feel about discussing condom use and other safer sex methods with their sexual partners?

The counsellor should anticipate that some information and discussions might be met with embarrassment, laughter or anger and denial depending on the person and the cultural context.
PSYCHOSOCIAL ASPECTS OF HIV COUNSELLING

A psychosocial perspective is fundamental to HIV/AIDS counselling. This psychosocial perspective sees the client in the context of his/her social environment. The counsellor should recognize that personality traits, as well as the social environment will influence the client's behaviour. Therefore, central goal of counselling is to restore or maintain the client's relationships with family, friends and the community. This may involve working through the anxieties that the family and friends of the infected person may have regarding their own health or future. In addition, physical contact with the infected person should be encouraged as an important way of overcoming isolation.

Psychological Stress of HIV/AIDS

A diagnosis of HIV infection will create considerable psychological stress. The conditions that most people experience are uncertainty and adjustment. The news of HIV infection creates uncertainty about all aspects of the person's life, including the quality and length of life, the effect of opportunistic infections and the response of society to the illness. These issues need to be discussed openly and frankly. The person diagnosed with HIV must also make a variety of adjustments. There is no way of predicting how a person will react to the news of a positive test result, however, the following responses are some of the possible reactions that must be attended to in counselling.

Shock:

Shock is a normal response to life-threatening news. Common shock reactions include:

- Numbness, "stunned" silence or disbelief
- Confusions, distractibility or uncertainty about present and future circumstances.
- Despair

Counselling Strategies:

Emotional instability (eg. moving quickly and unpredictably from tears to laughter and visa versa). Withdrawal, distancing from present issues and circumstances, reluctance to become involved in conversation or counselling, or activities and plans for treatment or for the future.

Counselling Strategies:

Although shock is a normal response to hearing the news of a life-threatening illness, it is important to explore the feelings the client has related to shock. As these feelings are aired, it is more likely that the effects of shock will diminish.

Denial:

Some people respond to the news of their infection or disease by denying it. While initial denial can help reduce stress, if it persists, it can prevent appropriate changes in behaviour and adjustments in life, necessary to cope with HIV and to prevent transmission. If denial is not challenged, people may not accept the social responsibilities that go with being infected.

Counselling Strategies:

The counsellor must broach this issue and challenge the client about his/her denial. This should be done in a supportive manner, however, such topic must be brought into the open. Often challenging the client about his/her denial will provide an opportunity to break through this impasse.

Anger

Some people become angry about the test result. They may engage in destructive behaviour such as harming themselves or others. With progressing illness, the person may become unfit for work. Boredom, with a life that is increasingly restricted in diet, activity and social contacts may be a source of anger. Anger can be expressed as irritability or unprovoked outbursts, sometimes triggered by seemingly trivial issues. Anger can also be directed inwards in the form of self-blame and self-destructive behaviours.

Counselling Strategies:

The counsellor should share his/her hunches about the feelings of anger expressed verbally or
non-verbally by the client. With this opening, the client can more freely explore and examine his feelings. As these feelings are discussed openly, the client is more able to confront his/her feelings and deal with them appropriately.

**Fear**

People diagnosed with HIV infection have many fears. The fear of death or of dying alone is very common. Other common fears may include fear of desertion, rejection, leaving children/family uncared for, disability, loss of bodily or mental functions, and loss of confidentiality of privacy. Fear may also be based on the experiences of others or from lack of accurate, understandable HIV/AIDS information.

**Counselling Strategies:**

If the counsellor suspects that the client is feeling fearful, he/she must explore these feelings with the client. As the client explores the experience of fear, he/she is more able to face this fear in a healthy way.

**Isolation**

The HIV-infected person may react by withdrawing from all social contacts. A significant factor is the fear of being abandoned, with the consequent reaction; "everyone is going to abandon me, so I will turn away first".

**Counselling Strategies:**

Initially, the counsellor should respect the need for isolation, while continuing a supportive counselling relationship. If isolation continues for a long period, the counsellor should explore the causes and support a change in attitude and behaviour. Evidence has shown that social support helps improve the client's quality of life, prolong life and promote a peaceful death.

**Loss**

People with HIV/AIDS experience feelings of loss about their ambitions, their physical attractiveness, potency, sexual relationships, status in the community, finances, stability and independence. As the need for physical care increases, there will also be a loss of privacy and control over life. Loss of self-confidence is critical since it can undermine the individual's ability to cope with HIV/AIDS. Many will have to face their own physical vulnerability and mortality. Also many of these experiences cannot be avoided, effective counselling will alleviate much of the significant stress caused by these losses

**Counselling Strategies:**

The client should be encouraged to explore his/her feelings of loss. In follow-up counselling session, these feelings should be revisited as situations and experiences may change. As clients face the many losses they experience, they are better able to cope and adjust to their loss. In addition, with exploration of certain losses, these experiences can be reverted. For example, exploring the loss of sexual relationships can lead to discussion about other forms of sexual expression.

**Grief**

People with HIV/AIDS often have deep feelings of grief over the losses they had experienced, or had anticipated for the future. They may also sense the grief of close family members and others who care for them and witness their declining health. In addition, family members themselves grieve the declining health and eventual death of a loved one.

**Counselling Strategies:**

Counsellors must be aware of these feelings of grief for both the client and the family members and help them explore these feelings. The purpose of such counselling is to explore the feelings associated with grief, and help the client and family members experience grief in a more manageable way. Anticipatory grief management is also helpful. This can be accomplished by sensitively approaching the subject of loss and death and helping the client (individual and family) explore how they will manage this grieving process.

**Guilt**

When HIV infection is diagnosed, there is usually a feeling of guilt about the possibility of having infected others (especially spouses and children), or about the behaviour that may have resulted in the HIV infection (eg, unsafe sexual experiences or injecting drug
There is also guilt about the sadness; disruption and loss that the illness will cause loved ones. Counsellors must help the client fully explore feelings of guilt. If these feelings are not fully examined, there is a tendency for them to magnify as the illness progresses. Unresolved guilt will cause the client to become sicker more quickly and might result in premature death.

**Counselling Strategies:**

The counsellor should not assume to know if the client is experiencing guilt, or what the client might feel guilty about. However, it is appropriate for the counsellor to say; "many people feel guilty when they realise they are HIV infected, is this something you are feeling?" In this way, the subject can be approached, but the client is given the opportunity to explore this feeling for him/herself.

**Depression**

Depression may arise from the realization that the virus infected the body, without any hope for a cure, which often results in feelings of powerlessness. A client may also become depressed by loss of personal control that may be associated with repeated medical examinations. Similarly, experiencing such things as the loss of potential for procreating or parenting and for long-term planning may contribute to depression.

**Counselling Strategies:**

Depression manifests itself in different ways. The person may become quiet or withdrawn. Anger, irritability or sudden outbursts might also be signs of depression. The client may also verbalise their feelings of depression. If the counselor suspects that the client is depressed, it is important to share that suspicion with the client so that full exploration of his/her feelings can take place. As the feelings of depression are verbalized, they become more accessible to the client and this will help the client to cope and to manage his/her feelings.

**Anxiety**

Anxiety can quickly become a prevailing feeling for the person living with HIV/AIDS. This anxiety often stems from chronic uncertainty about their illness and its progression. In addition, the client often experiences declining ability to function efficiently and loss of physical and financial independence.

**Counselling Strategies:**

The client usually manifests signs of anxiety that the counsellor can then address openly. If these anxieties are masked, then the counsellor can suggest; "many people experience feelings of anxiety about how their illness will progress and what that will mean for the person's life and financial security. "Have you experienced feeling anxious about your condition and your future? In this way, the feelings can be explored and anticipated. This anticipatory guidance often helps the client cope better as the illness progresses.

**Loss of Self-esteem**

Self-esteem is often threatened as soon as HIV is diagnosed. Rejection by neighbors, co-workers, acquaintances, and loved ones can cause loss of social status and confidence, leading to feelings of reduced self-worth. The physical impact of HIV-related diseases that bring, for example, facial disfigurement, unsightly tumours, physical wasting, loss of physical strength or bodily control can compound the problem.

**Counselling Strategies:**

The counsellor should raise these issues with the client. Ignoring physical changes will impede effective counselling. Addressing these issues and exploring how the client is feeling about their condition will help them cope with their changing condition.
**Suicidal thoughts, plans and actions**

People who learn that they are HIV-infected have a significantly increased risk of thinking, planning and attempting or committing suicide. Suicide may be seen as a way of avoiding their own pain or of lessening that of loved ones. Suicide may be active (deliberate self-injury resulting in death) or passive (self-destructive behaviour such as concealing the onset of a possibly fatal complication from an opportunistic infection).

**Counselling Strategies:**

The counsellor must assess whether the client has suicidal tendencies and approach this topic with sensitivity and clarity. The counsellor must also try to assess the gravity of the situation i.e. whether the individual is in thought phase (thinking about committing suicide), planning phase (thinking how to commit suicide) or is in the action phase. It is imperative to engage in open discussion on this topic. Often talking through these feelings will help alleviate these suicidal thoughts and actions. Counselling strategies must be planned considering the stage client is in.

**Hypochondria**

Excessive preoccupation with health or even the smallest physical changes can lead to hypochondria. This may be temporarily following the diagnosis, or it may persist where adjustment to the disease is difficult.

**Counselling Strategies:**

The counsellor should sensitively address the client's preoccupation with his/her own illness and concerns. It should be noted that some preoccupation is normal and so this topic should be addressed only if the client appears to be overly absorbed in his/her own condition. It is better to hold this hunch in check and only broach the subject if the client persists in this self-preoccupation, to the detriment of other people in his/her life or to his/her own well-being.

**Spiritual Concerns:**

The fear of death or other common reactions to an incurable illness may create or increase the individuals interest in spiritual matters.

Expressions of sin, guilt, forgiveness, reconciliation, and acceptance may appear.

**Counselling Strategies:**

The counsellor should approach this subject, if the client does not do so for him/herself. Referral to a spiritual leader might be an important strategy.

**Additional Complications**

Factors affecting the severity of the client's psychological state might be also include:

- The person's physical condition;
- How well prepared the person is for the news of HIV infection;
- How well the person is supported by his/her family and in the community and how readily he/she can call on the assistance of family and friends;
- The person's prior personality and psychological condition; and
- The cultural and spiritual values of the person, his/her beliefs and values about HIV/AIDS and his/her attitude towards death.
COUNSELLING SKILLS AND RESOURCES

Counselling is a complex and active process, and can be learned only through practice and dynamic interaction. The process of learning counselling skills requires constant practice and feedback from trainers or peers. Counselling differs from conversation in the following ways:

- it is purposeful: every counselling session has a particular aim that is achievable;
- specific: the counselling session deals with a specific concern or issue; and is
- focused toward a desired goal.

Accordingly, counselling aims to:

- clarify the problems presented by the client;
- provide necessary information;
- explore alternative options and resources;
- enable selection of realistic alternatives; and
- stimulate motivation toward effective problem solving and decision making.

Common features and requirements of effective counselling include:

- **Time**: it is essential to provide enough time for the effective counselling to take place. Also, it takes time to develop trust in the relationship. However, in many work situations, it is very difficult to make time to complete a whole counselling session. In this case, it should be noted that effective interpersonal communication can occur in a very limited amount of time. That is, effective communication can often occur in a brief encounter. Some people may require many counselling sessions in order to explore their problems, acknowledge the need to change a particular behaviour, to learn protective methods, begin to effectively solve problem and learn some necessary negotiating skills.

- **Acceptance and Respect**: people with HIV/AIDS should feel that they are fully accepted by the counsellor. The counsellor must be self aware and non-judgemental in the counselling session.

- **Consistency and accuracy**: any information provided in the counselling session must be consistent over time. The counsellor therefore, needs to have a full knowledge of the facts related to HIV/AIDS, or have the ability to seek out the knowledge that he/she lacks. HIV/AIDS information is changing rapidly, and the counsellor must keep up with this knowledge development.

- **Confidentiality**: trust is one of the most important factors in the relationship between the counsellor and the client. It enhances the opportunity for deep exploration of the client's condition and improves the chances that the client will act decisively on the information provided. Confidentiality ensures that any reference to or discussion about a client (except within a professional relationship) will not be undertaken without the express consent of the client.

- **Sensitivity and tactfulness**: although it is essential to raise issues related to sexuality and/or drug use, such discussions should be undertaken with sensitivity to the client's concern and presenting problem. These sensitive topics should be directed toward helping the client explore emotional issues, solve important concerns and make healthy decisions.
Stages in the Counselling Relationship

Each counselling session should be structured around a beginning, middle and end. In some circumstances, there might only be an opportunity for one counselling session. However, whenever possible, follow-up counselling sessions should be planned. The stages of each counselling session should include:

Beginning Stage: The beginning of the counselling session is very important as it provides an opportunity to establish a respectful, trusting relationship. Confidentiality should be discussed at this stage. Allow time for the client to tell his/her story. This story telling might appear disjointed, however, providing time to let the client express him/herself is very important. At this stage, do not interrupt the client except to summarize or paraphrase certain issues. The most important counselling strategy in the early stages is to listen attentively. In follow up counselling sessions, a recap of the activities that the client has undertaken or an exploration of the issues and problems he/she has faced since the previous session should be explored.

Middle Stage: Once the client begins to trust the counsellor and the initial story has been told, open-ended questions can now be raised and a case history taken. At this stage a plan of action is put in place. One of the most difficult and critical tasks is to encourage the client to share his/her condition with a spouse, partner, or family and friends. In addition, the counsellor should, (a) support the continuing expression and discussion of feelings, (b) if necessary, refer to available formal and informal resources, (c) monitor progress and modify plans as necessary, (d) promote the continuation of changes in behaviour and (e) help the person to move towards acceptance and control.

End Stage: Each counselling session should be brought to a satisfactory conclusion. The client should be aware of the progress he/she is making and have plans for further behavioural change. This strategy provides a sense of completion to the counselling session with a planned movement forward. When the counselling sessions are to be completed, this final stage should be carefully planned. The counsellor may increase the interval between visits so as to let the client gain increased independence with the knowledge that the counsellor is still available if necessary. The counsellor should end the counselling sessions only when it is certain that the client can cope and adequately plan for day-to-day functioning and has a support system (eg. family, friends, support group etc) in place. Finally, the counsellor should support the maintenance of behavioural change and make sure that all needed and available resources have been identified and are being used. It is important to provide an opportunity for the client to re-enter counselling if it is deemed necessary.

Effective Interpersonal Communication Skills

Counselling involves communication about sensitive issues and requires deep exploration of the client's issues and concerns. For this reason, the counsellor should develop the following interpersonal communication skills:

- **Active Listening:** The counsellor indicates by words, expression and gesture that he/she understands what the client is saying. Such skill as nodding and reflecting back what the client is saying are important.

- **Encouraging:** Some people do not express their feelings openly, even though they may feel them deeply. The counsellor should encourage the expression of feelings. It is only when people work through their feelings that they can begin constructive change. Words like, "yes-please continue" can be very encouraging.

- **Recognising:** The counsellor should be skilled in recognising and distinguishing various emotions the client is experiencing. Statements such as "that must be very difficult to accept" demonstrate the counsellor's ability to recognise particularly difficult issues.

- **Acknowledging:** The counsellor should acknowledge feelings such as anger, sadness and fear in a direct, unemotional way. Statements such as "I understand that this is not easy for you" are helpful.

- **Effective Questioning:** Counsellors use questions to help clients express their feelings and problems. These questions should be open-ended, aimed promoting
further exploration. Therefore, rarely are closed questions that require only a "yes" or "no" answer helpful. They should also enable the client to give a variety of answers "please tell me what you know about…", or "how do you think your wife will respond to this information?" are exploratory open-ended questions.

- **Empathising:** Empathy is more than sympathy; it involves trying to place oneself in another person's situation. This is a difficult skill to fully master as it requires the counsellor to suspend their own feelings and judgement and to enter the experience of the other. This is not to say that the counsellor looses his/herself in the process, instead, it is a skill of placing oneself into the "shoes" of another, and reflecting on the events experiences, emotions, and concerns. A statement such as I can see you’re feeling very anxious about..." is an effective empathic response. This response captures the feeling of the client while being specific about the reason the feeling has occurred.

- **Respecting:** Counsellors should respect clients' views and beliefs. They can show this respect by asking a client to explain unfamiliar aspects of their beliefs and values. These beliefs and values might be cultural, traditional or based on personal experience. Statements such as, "I am not familiar with this, can you tell me more". Another way to show respect is to listen attentively and paraphrase what is heard.

- **Clarifying:** The counsellor tries to clarify either what the client has said. For example, "do you mean...?", or presenting factual information. For example, "no, HIV is not transmitted by touching the infected person".

- **Paraphrasing:** Clients can tell when they are being understood when the counsellor repeats what the client has said, using his/her own words. Statements such as, "so you are saying that...". In this way, the client can either agree with the paraphrase, or clarify his/her statement.

- **Challenging:** The counsellor should confront the client if he/she appears to be avoiding important issues or when the client has not followed through with an agreed rather than one answer. For example upon action plan. This challenging can be sensitive so that the client can see it as a positive act, and not an expression of anger or blame. An effective challenge might be, "last week you said that you were going to talk to your wife about your illness, what has got in the way of you doing this?"

- **Repeating:** At times of stress and crisis, people may not understand everything they are told because they are in a state of denial, or feel overwhelmed. The counsellor should not hesitate to repeat important information. In fact, most people need to be told more than once, in order for certain information to be fully understood and retained.

- **Emphasizing:** Often people avoid focusing on the real problem. The counsellor should highlight the most critical issues. For example "of all the things we have covered today, the point that stands out for me is...", or, "can I just emphasize the following points...?" In this way, the client has an opportunity to focus on some important issues that have been raised in the counselling session.

- **Structuring:** Structuring determines which problems or issues need immediate attention and those that can be postponed to a latter session. It is an essential planning and helps to structure the ongoing counselling process. However, it is important to note that the structuring that occurs in one session might not be appropriate in subsequent. Structuring provides the counsellor and the client with a sense of movement. Such statements as, "there are three main issues we are facing" help focus and structure the session and subsequent sessions.

- **Motivating:** Counsellors should try to motivate clients by offering positive encouragement of new behaviours. For
example, the counsellor might explain how the changed behaviours will help protect the client's loved ones. This may be a critical source of motivation. Another source of motivation is to explore what might happen if the client does not change their risk behaviour. Anticipating potential problems can be another source of motivation. For example, "what do you think might happen if you continue to have sex with commercial sex workers?"

- **Summarizing:** This is very much like paraphrasing in that it helps to ensure that the client and the counsellor understand one another correctly. Summarizing can be done by the client or the counsellor. At the end of the session, it might be important to summarize the important points that have been covered that session. Such statements as, "To summarize then, these are the issues..." help focus and highlight the major issues in the counselling session.

**Common Errors in Counselling**

The principles of effective counselling are easy to read but difficult to apply. Continuous practice with feedback is essential to fully incorporate these skills into a helping relationship. Some common counselling error include:

- **Controlling** the session rather than encouraging the client's spontaneous expression of feelings and need.

- **Judging** by showing non-verbal disapproval or by making statements that indicate that the client is not meeting the counsellor's standards.

- **Moralizing**, preaching, and patronizing - telling people how they ought to behave or lead their lives.

- **Labelling**, rather than trying to find out the person's motivation, fears and anxieties.

- **Unwarranted reassuring** - trying to induce undue optimism by making light of the client's version of the problem.

- **Not accepting** the client's feelings - saying they should feel differently.

- **Advising** before the client has enough information or time to arrive at a personal solution.

- **Interrogating** - using questions in an accusatory way. "Why" questions often sound accusatory.

- **Encouraging** dependence - increasing the client's need for the counsellors continuing presence and guidance.

- **Cajoling** - persuading the client to accept new behaviour by flattery or deceit.

**Non-verbal Communication**

There is research evidence that suggests that between 70-90% of all communication is non-verbal. This means that a counsellor must be very self aware of his/her own beliefs and values and how these might affect the counselling session. In addition, counsellors should pay close attention to both the verbal and non-verbal messages of the client. The following chart contrasts positive and negative nonverbal counselling techniques:
### Positive

- Looks the client in the eye
- Uses attentive facial expression, body movement and posture.
- Sits a suitable distance from the client
- Does not speak too quickly, or too slowly
- Uses occasional gestures such as nods, to acknowledge the client
- If appropriate, uses humour to reduce the tension
- Uses a tone of voice similar to the client's

### Negative

- Looks away frequently
- Frowns, scowls or yawns
- Sits at an inappropriate distance
- Speaks too quickly, or too slowly
- Appears un-reactive and fails to respond to the client's words or gestures
- Uses humour inappropriately, or conversely, increases the tension by too heavy and serious a tone
- Uses an unpleasant tone of voice

## Introducing Sensitive Topics

Talking about how HIV/AIDS is transmitted sexually or through injecting drug use requires sensitivity on the part of the counsellor. Introducing these sensitive topics is essential, however, many counsellors find in depth discussion on these topics fully to be problematic. Information about intimate behaviour will have to be gathered and interpreted. Some client behaviours will be disapproved of by the general population, and in some circumstances, even illegal. The first, and most important task for the counsellor is to examine his/her own abilities to discuss intimate and often traditionally unsanctioned behaviours in an open, non-judgemental manner. This can be challenging for the counsellor. It is then the responsibility of the counsellor to encourage open discussion with his/her client. There is no simple formula for encouraging people to talk about sensitive topics. Effective discussion will depend in large measure on the ability of the counsellor to:

- Counsel to the emotional and intellectual level of the client;
- Provide an atmosphere where the client feels safe and secure by establishing a supportive, non-judgemental relationship; and
- Demonstrate his/her own ease in talking about topics usually avoided in ordinary social life or in medical consultations.

All HIV counselling will require skill, tact and sensitivity. In some circumstances, the counsellor may have to enquire about taboos or unusual practices. The counsellor should also realize that the risk of HIV infection may involve secret behaviours. In some circumstances, the counsellor should understand and be willing to use local or slang expressions. Counselling regarding sensitive and deeply personal topics requires the counsellor to:

- Feel secure and at ease when enquiring about intimate matters that are rarely openly discussed, to enable clients to talk about sensitive topics;
- Focus the discussion on specific at risk practices and behaviours. The detail needed (eg. bisexuality, homosexuality, unprotected heterosexuality with multiple partners, injecting drug practices etc.) may embarrass the client, and even the counsellor, in some instances, however, such open discussion and counselling is essential.

In order to counsel effectively, the counsellor should ask him/herself the following questions:

- Which sexual practices will be most difficult for me to talk about?
- What everyday words will clients use or avoid when explaining risk practices or behaviours?
- How will I approach counselling with clients who differ from me culturally, sexually, or of a different age?
• How will I explain the need to discuss intimate or taboo subjects?

Counselling Strategies: The first step is to be self aware about the counsellor's beliefs, values, assumptions and judgements about issues related to HIV transmission. It is also imperative that the client understands that confidentiality will be maintained. Developing a trusting, respectful relationship with the client before approaching sensitive topics is essential. If time is limited, opening to the exploration of sensitive topic must be carried out, however, the counsellor must continually reassure the client that confidentiality will be maintained. Explain to the client that preventing the spread of HIV requires open and honest discussion about his/her life style and sexual or drug related practices. Start the counselling session by explaining to the client that discussion of sensitive, perhaps embarrassing subjects will be necessary. Be clear and open about what issues need to be covered in the counselling session. Be sure that the counsellor is appropriate for the client. That is, usually a man should counsel a man, and a woman should counsel a woman. When group or family counselling occurs, then a decision should be made about the appropriate gender of the counsellor. Often generalizing the practice to other people will allow a person to talk more freely at the beginning of the counselling session. For example, the counsellor may say, "some people around here say that you can only get HIV if you have sex with many partners (eg. singing and dancing girls). Have you heard this?"

Questions are also critical in counselling (see Appendix B for examples of good HIV questioning). Only through honest and open dialogue can the counsellor illicit information about risk, check the understanding, or misunderstanding of facts and assist the client in deciding about the courses of action. Such questions might address relationships, the type of sexual practices the client engages in and the client's knowledge about HIV/AIDS including modes of transmission. This topic will be covered in more detail under the chapter on HIV counselling.

Crisis Counselling

Crisis counselling is most often necessary when the client perceives HIV/AIDS as a threat to his/her survival and/or to the social stigma he/she perceives to be associated with the news. The crisis event usually has four stages. The first stage is one of shock when the client realizes that something is wrong, symptoms appear or when the HIV test is positive (after a second confirming test result). This event often leads the client to recoil from the news (second stage). For example, the client may struggle emotionally with the full implications of the test result. Some clients will demand another test at another testing facility to confirm the diagnosis. Although these emotions are normal, they should be transitory.

Some clients quickly begin to come to terms with the diagnosis, while others withdraw (stage three). At this stage, it is often appropriate to allow the client time to explore their emotions of fear, denial, shock etc. However, it is important not to allow the client to stay withdrawn and isolated from the counsellor or his/her family and friends. Such behaviours often lead to depression or denial of their condition. Such denial can be dangerous, as the prevention of HIV transmission often requires behavioural change (see Chapter 4 for details about how to counsel in these circumstances). If counselling is effective, and the client feels supported and understood, the client may move to the fourth stage, one of acceptance of his/her condition. This acceptance is the first step in promoting necessary behavioural change. An emotional crisis may result if a person feels:

• Intensely threatened;
• Completely surprised and caught unaware by events that are happening;
• Emotionally disturbed as a result of loss of control; and
• Emotionally paralysed because there does not seem to be any solutions to the problem, all efforts to resolve the situation appear hopeless, or the results appear to be overwhelming to the person.

Counselling Strategies: It should be noted that any event that is perceived by the client to be a crisis, should be treated as such by the counsellor. In this sense, the counsellor should begin by respecting and supporting the emotional crisis as the client sees it. It is very important at this stage not to “down play” the emotions of the
client or try to reason with him/her about the nature of the situation. Some clients become so anxious and overwhelmed that they cannot function normally. At this stage, the counsellor should actively listen to the client by responding and paraphrasing (addressed earlier in the chapter) his/her emotional concerns. When the client is in crisis, the counsellor should remain calm and accept the fear as genuine. The following counselling techniques are effective in a crisis:

- **Guided/structured questioning:** The counsellor can help the client explore his/her feelings by asking open-ended questions. For example, "At this stage, you are probably feeling very overwhelmed. I need to ask you a few questions to help us sort out what you are feeling" (see Appendix B for some examples of effective questions).

- **Acceptance:** Accepting the clients feelings as valid is an important strategy. For example, "I can see that you are feeling angry and questioning the result. This must be very hard for you to accept this diagnosis".

- **Emotional support:** As well as acceptance, the counsellor should provide emotional support to the client, while also providing a sense of direction. Statements such as, "Many people feel overwhelmed with the news when they first hear it. I can see that you are having some of these feelings yourself. As time goes on, we will be able to sort through these emotions and help you move forward with your future".

Some additional skills the counsellor can use in a crisis situation are:

- Staying in the present by focusing on the client's immediate expression of emotions;

- Checking whether the client shows the ability to start making some important decisions;

- Clarifying with the client what he/she regards as a crisis, and supporting the client to move toward reducing this emotional burden;

- Starting to work with the client on aspects of the crisis and to foster confidence that he/she can deal with future problems.

In a crisis situation, the client is unlikely to remember all that the counsellor tells him/her. Depending on the literacy level of the client, information should be written down and given to the client (see Appendix F for some examples of client information sheets). In addition, the counsellor should be prepared to repeat information, often many times, to ensure client understanding.

**Problem-solving Counselling**

Often the client feels able to deal with the crisis once some pressing problems have been addressed and acceptable solutions found. This strategy gives the client a feeling of self-efficacy. However, crisis counselling deals with the present, while problem-solving looks to the future. Some of the most important problem-solving techniques used by the counsellor involve mutual problem posing and planning. This planning should include how to prevent further HIV transmission, ways of coping with the reaction to HIV/AIDS, and seeking appropriate resources, including medical care. The counsellor should highlight the consequences of HIV infection and suggest possible approaches to address these problems. Once the client fully understands the consequences of HIV, the client and the counsellor can work together to assess how best to address these concerns. Clients are more likely to follow healthy decisions if they have taken part in the problem-solving process.

**Counselling Strategies:** The problem-solving approach is used to help clients to:

- Understand the nature of the illness;

- Think through the impact of the disease on their daily living;

- Gain the courage and personal skills for dealing with the problem; and

- Change behaviours to protect themselves and others.
Effective problem-solving counselling involves:

- Defining all aspects of the problem as the client sees it;
- Encouraging open discussion about the client’s feelings, while demonstrating support and reassurance that these feelings are normal;
- Assessing the client’s past and present problem-solving abilities;
- Reducing the problem into a number of manageable parts that can be more easily addressed. As the problem is broken down into manageable components, the client and counsellor are able to begin planning some problem-solving strategies;
- Discussing personal and other related resources available to the client.

**Decision-making Counselling**

Based on the awareness of risk behaviour or a diagnosis of infection, the client must make decisions about behaviour and other possible changes. Hopefully, these decisions will be made with growing emotional control and better understanding of the problem. Decision-making counselling helps the client to focus on often disturbing, but necessary decisions. Decisions that may need to be taken into account include:

- Who will need to be told of the condition, and how and when will they be told?
- How will the client handle certain legal, financial or other matters?
- Who will be asked to provide emotional support and physical care?
- Who will care for the children?
- What kind of change can be made in diet or lifestyle in order to stay as healthy as possible?

**Counselling Strategies:** As trust is established between the counsellor and the client, addressing these questions (and perhaps others) will be very important. It will also be important for the counsellor to judge when the client is ready to begin this decision-making process. Only when the time is right will the client be able to move toward effective problem-solving and decision-making (the issue of timing was discussed earlier in this chapter). Consideration and ultimate resolution to these questions will help the client restore a sense of control and movement toward necessary conclusions.

**Developing Adequate Resource Networks**

As HIV infection progresses into AIDS, different medical and psychosocial needs emerge. The counsellor cannot (and should not) meet all these needs. Instead, the counsellor should be fully aware and refer the client to other available formal or informal resources. Formal resources include medical care services (e.g., health centres, clinics, hospitals etc.). Services that provide assistance with finances, food, transportation, other counsellors, and health care workers should also be made available to the client. Informal resources that include families and friends, religious leaders, traditional healers, community organizations and peer groups are also important. The counsellor can also encourage the formation of other resources and support where necessary. Information about these resources should be available to the client in the counselling session as well as being available in other formal and informal settings. The counsellor can help the client negotiate these resources and sometimes act as an advocate for the client. In addition, the counsellor can also help support the treatments and advice given from other resources. A key task of the counsellor is to mobilize or create additional resources for the HIV infected client. Counsellors also need a referral system for difficult cases. Links should be made with other psychologists and psychiatrists for this purpose. It is also very important that other formal and informal services know about this HIV counselling service. Information about this service should be provided to all organizations, both formal and informal, that care for someone living with HIV/AIDS.

**Self-help Peer Groups**

Self-help peer support networks are a valuable addition to counselling. The counsellor can refer
clients to these groups, if they exist, or they can help facilitate the formation of such groups. These support groups are often formed with the aid of nongovernmental organizations. Such peer support groups can help the client with issues related to particular risk behaviours that need to be changed. If peer support groups are not available, with the permission of both parties, the counsellor can introduce clients to one another, to aid in their psychosocial support. Matters that can be dealt with effectively through self-help peer support groups include:

- Learning about living with HIV infection. Self-help groups are often in a good position to provide information and mutual support,

- Helping care-givers and loved ones to handle the pressures of day-to-day living with sick or distressed people.

- Deciding how best to talk about HIV/AIDS with family, friends and other people who can provide support

- Peer support groups can organize discussion and training about how to adopt or maintain new risk reduction behaviours.
VOLUNTARY COUNSELLING AND HIV TESTING (VCT)

HIV counselling is a confidential dialogue between a client and counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. The counselling process includes evaluating the personal risk of HIV transmission and discussing how to prevent infection. It concentrates specifically on emotional and social issues related to possible and actual infection with HIV and AIDS. HIV counselling has as its objectives both prevention and care. It is important for counsellors to have a basic understanding of the HIV antibody tests that may be performed, as well as the necessity of confirmatory HIV antibody testing. Figure 1 provides an overview of the HIV counselling process.

<table>
<thead>
<tr>
<th>Figure 1: STRUCTURE OF THE COUNSELLING PROCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTRODUCTION</strong></td>
</tr>
<tr>
<td>• Greet the patient;</td>
</tr>
<tr>
<td>• Introduce yourself;</td>
</tr>
<tr>
<td>• Emphasise confidentiality;</td>
</tr>
<tr>
<td>• Explain the counseling process</td>
</tr>
<tr>
<td>(What will be done today)</td>
</tr>
<tr>
<td><strong>ASSESSMENT</strong></td>
</tr>
<tr>
<td>Ask the patient</td>
</tr>
<tr>
<td>• What concerns them;</td>
</tr>
<tr>
<td>• Who else knows;</td>
</tr>
<tr>
<td>• How does it effect their life;</td>
</tr>
<tr>
<td>• Allow “ventilation”</td>
</tr>
<tr>
<td><strong>INTERVENTION</strong></td>
</tr>
<tr>
<td>Working TOGETHER:</td>
</tr>
<tr>
<td>• Identify first and later priorities;</td>
</tr>
<tr>
<td>• Identify options for immediate management, and needs for later management;</td>
</tr>
<tr>
<td>• Emphasise prevention;</td>
</tr>
<tr>
<td>• Identify other appropriate support;</td>
</tr>
<tr>
<td>• Encourage the client in “taking charge”</td>
</tr>
<tr>
<td><strong>SUMMARY</strong></td>
</tr>
<tr>
<td>• Summarise what had happened and</td>
</tr>
<tr>
<td>What is left to do;</td>
</tr>
<tr>
<td>• Emphasise the “open door”;</td>
</tr>
<tr>
<td>• Check and clarify the patient’s understanding’</td>
</tr>
</tbody>
</table>
Antibody Testing

Any blood test used to detect HIV infection must have a high degree of sensitivity (the probability that the test will be positive if the patient is infected) and specificity (the probability that the test will be negative if the patient is uninfected). No antibody test is ever 100% sensitive and specific. Therefore, if available, all positive test results should be confirmed by retesting, preferably by a different test method. HIV antibody tests usually become positive within 3 months of the individual being infected with the virus (the window period). In some individuals, the test may not be positive until 6 months or longer (considered unusual). Tests for HIV detect the presence of antibodies to HIV, not the virus itself. The three main objectives for which HIV antibody testing is performed are:

- screening of donated blood;
- epidemiological surveillance of HIV prevalence;
- diagnosis of infection in individuals.

Screening of donated blood accounts for the majority of HIV tests performed in Pakistan. It is a highly cost-effective preventive intervention as the transmission of HIV through infected blood is at least 95%.

HIV testing was initially used for clinical confirmation of suspected HIV disease. More recently, people have been encouraged to attend voluntary counselling and testing (VCT) services to find out their HIV status. It is hoped that if people know their HIV status and are seronegative, they will adopt preventive measures to prevent future infection. If the person is seropositive, it is hoped that they will adopt risk reduction behaviours, learn to live positively, access care and support at an earlier stage, and plan for their own and their family's future.

Antibody tests:

Traditionally, HIV testing has been done using ELISA. However, there are various essential requirements for ELISAs to be performed accurately:

1. Laboratory equipment (eg. pipettes, microtitre trays, incubators, washers, and ELISA readers) must be available.
2. Constant supply of electricity and regular maintenance of equipment.
3. Skilled technicians.
4. Accurate storage and testing temperatures.

Recent advances in technology have led to various simple rapid tests being developed. Most of these tests come in a kit and require no reagent, equipment, training or specified temperature controls. Single tests can be performed at any time. These tests are as accurate as ELISA and the results can be received within hours. In Pakistan, the Rapid Single Test method is most widely used, with confirmation of an equivocal or sero-positive test usually being performed with ELISA. One advantage of the Single Rapid Test is that, in some circumstances, the client can wait for the result. It has been found that if the test result is delayed, some clients do not return for their result.

False positive result:

HIV tests have been developed to be especially sensitive and consequently, a positive result will sometimes be obtained even when there are no HIV antibodies in the blood. This is known as a false positive, and because of this, all positive results must be confirmed by another test method. A confirmed positive result means that the individual is infected with HIV.

False negative result:

This situation occurs when the blood tested gives a negative result for HIV antibodies when it should really have been positive, as the person is infected. The likelihood of a false negative test result must be discussed with patients if their history suggests that they have engaged in behaviour that are likely to put them at risk of HIV infection. In this situation, repeated testing over time may be necessary before they can be reassured that they are not infected with HIV. The most frequent reason that a false negative test result has been obtained is that the individual is newly infected (ie. the window period) and is not yet producing HIV antibodies. However, it is important to remember that someone who has
tested negative for HIV, can become infected the following day.

**Pre-test Counselling**

Pre test counselling should focus on two main topics: (a) the person's personal history of risk behaviours or having been exposed to HIV, and (b) assessment of the person's understanding of HIV/AIDS (including modes of transmission), and the person's previous experiences in crisis situations. The aim of pre-test counselling is to provide information about the technical aspects of testing and the possible personal, medical, social, psychological and legal implications of being diagnosed as either HIV positive or negative. Information should be up to date and given in a manner that is easy to understand. Testing of blood donors is different from testing of those suspected of having HIV/AIDS, however, both require enquiring about risk behaviours. Testing should be discussed as a positive act that is linked to changes in risk behaviour, coping and increasing the quality of life.

**Components of Pre-test**

**Counselling:** (see Appendix C for counsellor pre-test checklist).

**Assessment of risk:** Assessing the likelihood that the person has been exposed to HIV includes considering:

- Frequency and type of sexual practices, in particular, high risk practices such as vaginal and anal intercourse without a condom or unprotected sex with commercial sex workers.

- Being part of a group with high-risk prevalence for HIV infection (e.g. intravenous drug users, male and female commercial sex workers and their clients, prisoners, refugees, migrant workers, long haul lorry drivers, homosexual and bisexual men). In addition, health care workers and carers are at risk for HIV infection where the practice of universal precautions is problematic.

- Having received a blood transfusion, organ transplant, blood or blood products where HIV screening has not occurred. It should be noted that with even the most sensitive screening measures, some HIV infected blood may get into the general system.

- Having been exposed to non-sterile invasive procedures such as tattooing, scarification, and male circumcision

**Assessment of understanding:** The following questions should be asked in assessing the need for HIV testing:

- Why is the test being requested?

- What are the behaviour patterns or symptoms of concern?

- What does the person know about the test and its uses?

- What are the person’s beliefs and knowledge about HIV transmission and its relationship to at risk behaviours?

- Who could provide emotional and social support (e.g. family, friends, etc)?

- Has the person sought VCT before, if so, when, from whom, for what reason and what was the result?

- Has the person considered what to do, or how he/she would react if the result is positive, or if it is negative?

- Table 1 provides a checklist of issues to be discussed with the client in pre-test counselling (see Appendix C for a pre-test counselling checklist).

**Preparation for HIV testing:** Effective pre test counselling will prepare the person for the test by:

- Discussing confidentiality and informed consent for the HIV test;

- Explaining the implications of knowing one is or is not infected;

- Exploring the implications for marriage, pregnancy, finances, work, stigma etc;
• Facilitating discussion about ways to cope with knowing one's HIV status (e.g., has the person considered what to do or how she/he would react if the test is positive, or if the test is negative?);

• Promoting discussion on sexuality and sexual practices;

• Correcting myths, misinformations and misunderstandings related to HIV/AIDS.

• Promoting discussion on relationships especially the benefits of shared confidentiality between the person and his/her loved ones;

• Promoting discussion on sexual and drug related risk behaviours (as appropriate);

• Exploring emotional coping mechanisms and the availability of social support;

• Explaining how to prevent HIV transmission;

HIV counselling helps the person make informed choices. However, it is important to note that people who do not want pre-test counselling before taking the HIV test should not be required to do so. In addition, a decision to be tested should be an informed decision. Informed consent implies awareness of the possible implications of a test result (including the window period). Figure 2 provides a framework for pre and post-test counselling.
Table 1: HIV PRE-TEST COUNSELLING CHECKLIST

- Empahsise confidentiality
- Explore reasons for testing
- Explore risk history:
  - Unsafe sex – self and of partner
  - Injecting drug use – self and of partner
  - Blood/blood products/transplants received
  - Possibly non-sterile procedures: Tattooing, injections, scarification, circumcision
- Explore the significance of the “Window period” and the time elapsed since last risk exposure
- Explore and clarify HIV/AIDS knowledge
- Explore HIV test understanding and implications:
  - Marriage
  - Pregnancy
  - Relationships (eg. Does the partner know about the testing?)
  - Work
  - Stigma
  - Finance
  - Emotional coping
  - Social support available
- Explore and clarify knowledge about the test and testing procedures
- Discuss the value of testing:
  - If negative
    - A platform for constructive change
    - Confirms lack of antibodies
    - Remove uncertainty
  - If positive
    - A platform for constructive change
    - Certain knowledge
    - Protect self and partner
    - Plan for own and loved-ones future
- Discuss who should know the result if positive, and how they might be told
- Assess strategies for coping in the shorter and longer term
- Previous experience in managing health and other personal crises
- Discuss future prevention
  - Safe sex and condom use
  - Clean needle use
  - Options for managing risk situations
Symptoms or worries requesting HIV status

Counselling before testing, including assessment of risk behaviour, psychosocial conditions, and provision of oral and written factual information

Providing time to consider

Blood test declined

Blood sample taken

Blood sample taken

HIV Negative
Reinforcing appropriate behaviour and encouraging change of inappropriate behaviour

Explaining that even in a low risk situation, care needs to be taken to avoid infection and possible transmission

HIV Positive
Breaking the news sensitively;
Assessing capacity to manage news;
Providing time for discussion;
Helping to adjust to situation and making appropriate and reasonable plans

Providing on-going counseling that involves family, friends or others;
Mobilising family and community support;
Identifying other sources of support
Encouraging responsible behaviour

Providing continuing counseling,
Including stimulating motivation to reduce risks of transmission, where appropriate, identifying other sources of support, including medical, hospital, and possibly hospice care
Benefits of pre-test counselling: Access to pre-test counselling is not always available and some people might refuse this option. However, if the test is positive, there are considerable benefits to providing this service which include:

- Improved acceptance of HIV status and ability to cope.
- Empowerment, including greater involvement of the PLA in their care.
- Facilitation of behavioural change.
- Reducing the risk of mother-child transmission.
- Early management of opportunistic infections, contraceptive advice and other information and education.
- Provision of early social and peer support.
- Normalizing and de-stigmatising HIV/AIDS.
- Instilling hope and addressing the quality of life issues for the PLA.
- Planning for future care, making a will and considerations for future childcare.

Figure 2 provides a flow chart of the pre-test and post-test counselling process.

Post-test Counselling

The counselling session should begin by trying to put the person at ease. If possible, the room should be quiet, without the fear of being disturbed. Arrange the chairs so that bright light will not shine in anyone's eyes. The counsellor should then tell the person the test result in a clear and direct manner. The result (either positive or negative) should then be discussed, including how the person feels about the result. Providing further information might be necessary although the person may be shocked (no matter what the result), and may not fully take in all the information. However, in some circumstances, this might be the only chance to counsel this person and so asking them to repeat the information, or have some basic facts written down will be helpful (see Appendix F for basic client information sheets). It is important for the person to have time to reflect on the result and understand the next course of action. Ideally, couple and/or family counselling should be started and further counselling follow-up arranged.

HIV-positive Test Result Counselling

(The positive test result will only be given after the second HIV test confirms a positive result.) The counsellor should tell the person as gently as possible, providing emotional support and discussing how best to cope with the result. This is not the time for speculation, but time to give clear, factual explanations of what the news means. Assess the emotional impact of the news and validate the person's reactions as normal. Fear of dying, job loss, family acceptance, concern about the quality of life, the effects of treatment and response by society might be explored (see psychosocial aspects of HIV counselling Chapter 4 of these guidelines). If there is a concern that the person might not return for follow up counselling, then information about relevant related services might be included, such medical treatment for opportunistic infections, social services for financial and ongoing psychosocial support etc (see section on resource networks in Chapter 5 of these guidelines). However, if follow up counselling is an option, then it would be advisable to leave this information to a later date when the person is more able to absorb the details and explore some options. Assess the person's understanding and ability to use preventive methods. Free condoms can be given out during this session together with advice on how to use them and where to get more. Figure 3 provides a flow chart of the counselling process after a positive result, table 2 provides a checklist of issues to discuss with the client and Appendix D provides a counsellor checklist.
Counselling for HIV/AIDS 38

- Renew relationship
- Follow patient’s lead when to disclose
- State result clearly
- Wait:
  - Give time to absorb information
  - Give time for expression of feelings
  - LISTEN
- Integration of test result:
  - Intellectual
    - Explore understanding
    - Clarify understanding of the result
  - Emotional
    - Assess emotional impact
    - Validate reactions as normal
  - Behavioural
    - What will they do next-in immediate future
    - Assess understanding of and capacity for risk reduction
    - Explore factors relating to general health and immune functioning – stress, nutrition, exercise, alcohol and drug use, re-exposure to HIV
  - Interpersonal
    - Review who to inform
    - Review possible impact on partner, family, friends, and employer
    - Review how to break news – offer help and support
    - Plan to maximize support and minimize stress
  - Medical
    - Plan health checks and early intervention
    - Rationalise attendance for health interventions
- Arousing hope – Advice and empowerment:
  - A realistically hopeful message about what can be done without discounting their concerns
  - Focus on measures to maintain and improve quality of life
  - Empower participation in health issues
  - Express your availability, and the availability of other services, when needed
- Planning for the future:
  - Possibilities for constructive change
  - Support possibilities in the short term
  - Managing the stress of diagnosis, and reducing the potential for harm arising from stress reducing behaviour, such as substance misuse, impulsive behaviours, risky sex
  - Plan to address financial, occupational, legal, domestic, medical needs
  - Identify resources for on-going support, such as individual therapy, support groups, social network, spiritual network
- Provide appropriate brochures and information to take away
Introduction: Explore symptoms or worries leading to seeking HIV test

Pre—Test Counselling: Discussion confidentiality, assessment of knowledge about HIV/AIDS; assessment of risk behaviours; examination of psychosocial condition and social support; provision of oral or factual information on HIV/AIDS; anticipatory guidance about how the person might respond to the result of the test (either positive or negative)

Provide time for the person to consider whether to take the test or not

Obtain informed consent and blood test taken

Post-Test counseling: Assess the capacity to accept news; breaking the news sensitively and clearly; Providing time to allow the news to be taken in; exploration of feelings; help the person come to terms with the test result; make appropriate and reasonable plans; give basic fact sheet on HIV information. Provide free condoms (if available)

Provide follow-up counseling that involves family, friends or other (at the client’s discretion); help mobilize family/community support; identify other sources of support; exploring, promoting and educating for responsible behaviour change. Provide free condoms.

NB: If there is a concern that the person will not return for further counseling, include the counseling contained in the following box.

Provide on-going counseling; encourage peer support; encourage and motivate risk reduction behaviours; identify referral services and support (eg. medical, financial, spiritual, sexual health, etc.)
Counseling Table - Equivocal Result

How news of HIV infection is accepted or incorporated often depends on the following:

- The person's physical health. People who are ill often have a delayed response and can only absorb information when they grow stronger.

- How well the person has been prepared for the news.

- How well supported the person is, both in the community and by family and friends.

- The pre-test psychological condition of the person. Where psychological distress existed before the result, learning of the result could make this distress greater.

- The cultural and spiritual values attached to AIDS, illness and death. In some communities people might take a fatalistic attitude, whereas in other communities, AIDS is sometimes seen as evidence of antisocial or blasphemous behaviour.

Counselling and support may need to address feelings of shock, fear, loss, grief, guilt, depression, anxiety, denial, anger, suicidal activity or thinking, reduced self esteem and spiritual concerns etc. In addition, social issues such as loss of income, discrimination, social stigma, relationship changes and changing requirements for sexual expression might need to be explored. These issues have all been addressed at length in the chapter, Psychosocial and Cultural Aspects of Counselling.

Another important consideration is contact tracing. HIV infection can only be controlled when every effort is made to contact, test, and possibly treat the contacts. Contact tracing is a laborious task and often problematic. First the client should be assured that their name or other identifying properties would not be revealed to the contacts. Also, the client should be given the option of contacting the HIV-infected contacts him/herself. The counselor must stress the importance of this contact tracing to the client in order to control further spread of HIV. Appendix E contains a sample partner notification form.

HIV-negative Test Result Counselling

If the HIV test is negative, then counselling about at risk behaviours and methods of prevention are vitally important. Also, the counsellor must explain about the "window period" (between 3-6 months) when a negative result may be a false negative, if there is concern about the HIV status of the person, counsel them to return for a repeat test in 3-6 months. Ensure protection in the meanwhile, explaining that the client could become infected at any time. This is an ideal time to discuss sexual practices and preferences and potential drug abuse (particularly intravenous drug use) and other at risk behaviours. The person will probably be more open to learning about safe sex practices and modifying risk behaviours and be willing to consider necessary behaviour changes. Free condoms can be given out during this session together with advice on how to use them and where to get more when needed.

Figure 4 provides a flow chart of the counselling process for a negative test result, and Table 3 contains the issues that should be discussed in the counselling session. Appendix D contains a post-test counselling checklist.
Introduction: Explore symptoms or worries leading to seeking HIV test

Pre-Test Counseling:
Discussion about confidentiality, assessment of knowledge about HIV/AIDS; assessment of risk behaviours; examination of psychosocial condition and social support; provision of oral or factual information on HIV/AIDS; anticipatory guidance about how the person might respond to the result of the test (either positive or negative)

Provide time for the person to consider whether to take the test or not

Obtain informed consent and blood test taken

Post-Test counseling:
Break the news of the negative test result clearly; provide time for the news to be taken in; explore feelings; engage in problem-solving, and decision-making to promote reduction in risk behaviour; provide factual information on HIV transmission and demonstrate condom use; request a repeat demonstration of condom use; provide time for the client to repeat the information provided; explore/assess the capacity of the client to make the behaviour changes; explain with window period; refer to other agencies if necessary (eg STD treatment, MCH clinic, etc. Provide free condoms (if available)

Follow-up counseling to monitor and support behaviour changes; encourage peer support; provide further information if necessary. If concerned about continued at risk behaviour, explain the window period and the chance of still becoming infected, and encourage the client to return in six (06) months for re-testing.
Counselling After an Equivocal Test or Positive First Test when a Second (confirmatory) Test Should be Performed

There are times when a test is unequivocal (uncertain) and a second test must be carried out. Also, if the first HIV test is positive, a second, different test should be performed to confirm (or not) the initial test. Counselling in such circumstances will be slightly different from the counselling for a positive or negative test result. First, the client must be told the news of the uncertain test result. It is usual practice to explain to the client that the first test is inconclusive, and a second (different) test should be performed. See figure 5 for the decision flow of counselling for this equivocal result. Counselling should then follow the same guidelines as those for a negative test result (see the previous guidelines for counselling of HIV-negative test results).

Continued Counselling and Support

The HIV-infected person and his/her family might require further counselling and support. Such care helps improve their quality of life as well as enhancing their ability to cope and make informed decisions about ongoing care. Counselling and support might include encouraging the PLA to join a peer support group where psychosocial and instrumental support as well as education and treatment options may be addressed (see the guidelines for Self-help Peer Groups in the Chapter 5, Counselling Skills and Resources). Where services exist, further individual/family counselling might also be beneficial. In addition, referral to other agencies, organizations and services will be beneficial (see Developing Adequate Resource Network guidelines in chapter 5, Counselling Skills and Resources).

POST-TEST COUNSELING CHEKLIST – NEGATIVE RESULT

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renew relationship</td>
<td></td>
</tr>
<tr>
<td>Explain negative result</td>
<td>Give time to reflect, Allow time to express feelings</td>
</tr>
<tr>
<td>Explain lack of immunity to future infections</td>
<td></td>
</tr>
<tr>
<td>Check and confirm understanding of HIV</td>
<td></td>
</tr>
<tr>
<td>Clarify doubts and misconceptions about HIV and the test</td>
<td></td>
</tr>
<tr>
<td>Evaluate the need for re-testing</td>
<td>(e.g. after the “window period”, and/or occupational exposure)</td>
</tr>
<tr>
<td>Address &quot;survivor&quot; reactions and other, possibly unexpected emotional responses</td>
<td></td>
</tr>
<tr>
<td>Identify potential services for onward referral to manage related issues (e.g. Risk arising from alcohol/drug use)</td>
<td></td>
</tr>
<tr>
<td>Repeat HIV prevention discussion</td>
<td>A platform for constructive change, Safe sex and condom use, Clean needle use, Options for managing risk situations, Discussing prevention socially and domestically</td>
</tr>
</tbody>
</table>
### Pre-Test Counseling:
Discuss confidentiality; explain that the test result is inconclusive, and a second test should be taken (using another test method) to ensure accuracy of the result; assess current at risk behaviours; or support the behaviour changes the client has made; examine the client's psychosocial condition, and social support; provide oral or factual information on HIV/AIDS; provide anticipatory guidance about how the person might respond to the result of the test (either positive or negative).

- Provide time for the person to consider whether to take the second test or not.
- Obtain informed consent and blood test taken.

### Post-Test Counseling:
Depending upon the result of the second test, follow the guidelines outlined for post-test counseling for positive or negative test results.

---

### Bereavement Counselling

Families and friends often have little social support, or may have become isolated while the PLA was very ill. Bereavement support should be available before the person dies and for as long afterwards as people need it. People react to death in different ways and need different types of support. For some, it can take months or years to come to terms with loss. People's responses may be affected by the way the person died. If the PLA died alone and in pain this might create a different response than if he/she died peacefully, surrounded by loved ones. Those left behind often blame themselves if they think they could have done more. Bereavement counselling should:

- Give people an opportunity to talk about events leading up to the death, about the death itself and the rituals immediately after the death;
- Reassure people that feelings of disbelief, denial, sadness, pain and anger are normal;
- Provide people with the opportunity to express their feelings and concerns, especially if it is difficult for them to do this with friends and family;
- Enable family members and others to accept the reality of their loss and start to look to the future.

(See the guidelines for counselling under Psychosocial Perspectives in the chapter 4 "Psychosocial Aspects of Counselling").
**COUNSELLING AND EDUCATION**

HIV counselling and education have much in common, such as their joint dependence on the ability of the provider to communicate effectively, the role of providing accurate information on HIV prevention and care, the need to be culturally sensitive, and the need to assess the knowledge of the client before providing information. However, there are also considerable differences between counselling and education. Counselling is a confidential communication that is provided in response to the needs of the client and that provides emotional support in order to assist individuals and families who may have HIV-related problems or concerns. The following table outlines these differences:

<table>
<thead>
<tr>
<th>EDUCATION</th>
<th>COUNSELLING</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Provides verbal information in a timely manner (on a need to know basis);</td>
<td>- Attends to the emotional needs of the client;</td>
</tr>
<tr>
<td>- Provides written information at an appropriate level of understanding;</td>
<td>- Clarifies client's issues and concerns;</td>
</tr>
<tr>
<td>- Reinforces learning by demonstration and repeat demonstration;</td>
<td>- Asks open-ended questions to fully explore client's concern;</td>
</tr>
<tr>
<td>- Role plays various educational strategies;</td>
<td>- Supports the client to fully explore concerns related to risk behaviours;</td>
</tr>
<tr>
<td>- Reinforces learning by requesting the client to repeat information;</td>
<td>- Summarizes and paraphrases salient issues of concern;</td>
</tr>
<tr>
<td>- Supports and motivates clients to undertake necessary behavioural change.</td>
<td>- Responds to client's needs for support and care;</td>
</tr>
<tr>
<td></td>
<td>- Encourages client to seek support from others (ie. Support groups);</td>
</tr>
<tr>
<td></td>
<td>- Makes necessary referrals to other care providers at the client's request.</td>
</tr>
</tbody>
</table>
It should be noted that although important differences exist between these two important skills, the HIV counsellor must be familiar with, and capable of conducting both. That is, the counsellor is both an effective interpersonal communicator and an educator. Prevention of HIV transmission requires that the counsellor be an educator, and a motivator to promote necessary behavioural change.

**Behavioural Change**

Throughout the world, a considerable amount of literature has been devoted to the psychological aspects of behavioural change. To summarize this literature, there is general agreement that promoting and ensuring necessary behavioural change is very challenging. In issues related to the prevention of HIV transmission, the adoption of necessary behavioural change is essential. Counsellors must judge how best each client will respond to changing at-risk behaviours. There is no set formula that will ensure changes in behaviour. Therefore, each client must be assessed to ascertain which counselling and motivational methods will be most effective. Usually, clients respond to support, encouragement and motivation. However, some clients respond better when challenged and confronted by their risk behaviours (see Chapter 5 for specific counselling skills). Some factors that might influence behavioural change in HIV positive clients include:

- The need to protect his/her family from HIV transmission;
- The need to appear trustworthy and responsible within his family and community;
- The desire to protect others (e.g. sex partners, injecting drug users etc.) from HIV infection;
- The client’s expressed desire to make necessary changes to his/her behaviour;
- Evidence that prolonged risk behaviour might contribute to further deterioration in his/her health;
- The fear of further infecting him/herself with HIV or other STDs;
- The fear that their risk behaviour will become known to the community;
- The fear of stigma and isolation by loved ones, and the general community if the risk behaviours continue;

Counsellors can assess which of these factors are present in each counselling session and promote behavioural change, based on the particular needs and desires of the client. It should be noted that other issues (not listed here) might also be the motivating factor leading to behavioural change. The important counselling strategy is one that highlights the factor that is most likely to promote behavioural change, and uses this factor to support and encourage risk reduction. Motivation, support and encouragement will be necessary over time, to help sustain behavioural change. Also, the counsellor should assess the cues that might trigger behavioural change in each session. Patient information should be provided (see Appendix F).

**The Use of Condoms**

The safest form of prevention of sexually transmitted HIV is abstinence. However, in most instances, such practices are neither realistic nor desirable. Barrier methods that prevent semen and other body fluid from passing from one partner to another are the next most effective preventive methods. These barrier methods also reduce the risk of STDs, however, they also act as a contraceptive. The most effective barrier method is the male condom. The female condom is also effective, however, this barrier method is less available of acceptable.

**Male condom:** the male condom is placed over the erect penis before any penetration has occurred. The condom then remains on the penis until after ejaculation when it should be immediately removed, knotted and discarded in a safe place such as a toilet, latrine or in a safe disposal unit. It is vitally important that people are given accurate information and an opportunity to practice using condoms. Information should be given about how to place the condom on the erect penis, leaving a space at the top to receive the
ejaculate, how to unroll the condom down the shaft of the penis to the base, how to ensure that the condom remains in place throughout intercourse, and how to remove the condom before the penis loses its erection. Practice using condoms on a model or other article (such as a banana or cucumber etc) are important. A new condom must be used for each sexual act and any damaged condom should be removed immediately and a new one applied. It is essential to have free, or very cheap condoms available in places where people can access them in private and without embarrassment. Easy access to condoms should be available for both men and women.

Counselling Strategies: Counsellors should feel comfortable with discussing male condom use and with demonstrating, on a model, how the condom should be applied and removed. The counsellor should ask the client to repeat the demonstration.

Female condom: The female condom is a soft yet strong polyurethane sheath, about the same length as the male condom, but wider. A plastic ring at the closed end helps keep the condom fixed within the vagina during sex. A larger ring at the opening stays outside the vagina, spreading over the woman's external genital area. The female condom provides extra protection to men and women because it covers both the entrance to the vagina and to the base of the penis. These are areas where STD sores make it easy for HIV to enter. Female condoms should only be used once and do not need a prescription. However, they are more expensive than male condoms and not as easily acceptable or accessible. Because the external ring is visible outside the vagina, using a female condom might require the agreement of both partners. However, because it can be inserted hours before intercourse, it can provide protection in situations where consumption of alcohol or drugs may reduce the chances that a male condom will be used. The condom is inserted with the finger, making sure no damage is done to the polyurethane by fingernails or other sharp objects. The condom should then fit snugly against the cervix. During intercourse, it is necessary to guide the penis in or check that the penis has entered the condom and not entered the vagina outside the condom wall. The condom should be removed as soon as possible after male ejaculation and disposed of in the same ways as the male condom.

Counselling Strategies: It is important for the counsellor to ascertain whether the female condom is available in his/her area, if the condom is available, then this option should be provided to the client with a description on how to use the condom and how to discard the condom after use.

Other barrier methods: There are other barrier methods that help reduce the sexual transmission of HIV, but these are less reliable, and often not as easily available. The female diaphragm prevents semen from entering the cervix, however, it does not protect the vagina or the external genitalia from exposure to HIV.

Injecting Drug Users and other Mood Altering Drugs

HIV can spread very rapidly among injecting drug users (IDU), and thus to their sex partners and eventually to their children. However, this spread can be prevented or slowed down significantly if interventions are designed which take into account the specific local conditions and characteristics of the IDUs. Injecting drug users are usually a hidden and stigmatised group because their behaviour is illegal. Often caught in a cycle of poverty and faced with the cost of the drugs, IDUs often engage in criminal activities such as theft, and in high risk behaviours for HIV infection such as commercial sex work and paid blood donation. The only effective responses to HIV transmission among IDUs to date are those based on the philosophy of harm reduction. Harm reduction is compatible with proven public health principles, and need not conflict with demand and supply reduction (law enforcement) programs. Harm reduction programs approach drug abuse primarily as a public health rather than a law and order issue. Such programs take into account;

Promoting use of sterile equipment:

The most common pathway for HIV transmission among IDUs is the sharing of non-sterile injecting equipment. Scarcity, or lack of access to safe injecting equipment, and legal sanctions against possessing injecting equipment are the two main reasons for reusing or sharing needles and syringes. Another reason is ignorance of the risks of HIV infection and prevention methods. The two
most basic strategies that have proven effective are:

- The sale (at minimum cost), or free supply of needles and syringes through pharmacies or other outlets; and
- Needle and syringe exchange programs.

These exchange programs must be linked to ensure that dirty syringes and needles are exchanged for sterile ones. In addition, a vital principle for community acceptance of these programs is to ensure that needles and syringes are safely and discretely disposed of after use, and do not pose a threat to the general population.

**Harm reduction:** Ball (1998) recommends a hierarchy of decision making related to the prevention of HIV through injecting drug use. At the top of the risk hierarchy is the indiscriminate sharing of injecting equipment, while at the bottom is abstinence from all drug use. In moving down the hierarchy, towards lowering risk, prevention programs may be initiated to promote behaviour change in:

- Reducing the frequency of sharing, and the number of sharing partners,
- Cleaning injecting equipment with bleach,
- Not sharing injecting equipment,
- Using sterile needles and syringes, and not sharing other equipment,
- Changing from the injection of illicit drugs to use of non-injecting drugs,
- Reducing the frequency of non-injecting drug use, and
- The abstinence from all drug use.

This hierarchy of decision-making can be a useful framework to consider HIV prevention programs. However, it should be noted that people do not fall neatly into one of these categories. For example, a person may regularly engage in a needle and syringe exchange program, but, because of unforeseen circumstances, finds him/herself sharing used injecting equipment. This hierarchy also assumes that there is collaboration between the principles of public health (i.e., safe injection practices) and law enforcement. This is not often the case. In order for HIV prevention programs to be effective, national and local policies must achieve a balance between attempts to reduce the supply and use of illicit drugs and support efforts to decrease unsafe injection practices.

The principles of harm reduction that have been proven effective in reducing HIV transmission in IDUs include:

- Education, especially peer education and counselling;
- Promotion of the use of sterile injecting equipment for every injection; increasing the availability of equipment; removing barriers to access to use of sterile equipment (especially policing and legal barriers);
- Increasing drug treatment availability, accessibility and options;
- Increasing access to primary health care, particularly through services designed to be “friendly” to, and appropriate for, the IDU community;
- Research and education performed in collaboration with the affected community.

**Other mood altering drugs:** It is important to note that although IDU carries the greatest risk of HIV transmission, taking other mood altering drugs can also promote at risk behaviours. Alcohol, and other legal and illegal drugs taken orally or as an inhalant can affect a person's decision-making capacity. In such circumstances, the use of condoms is less likely, and other risk behaviours and sexual practices might occur.

**Counselling Strategies:** The risk of HIV transmission is greater in the drug taking population because of the risks of injecting drug use, taking other mood altering drugs, and the practice of unprotected sexual relationships with potentially HIV-infected partners. Such counselling requires sensitivity (see Chapter 5), challenging the risk behaviours (see Chapter 4), and promoting risk reduction behavioural change discussed earlier in this chapter. The counsellor
should review the guidelines on effective communication, sensitivity, challenging (Chapter 5), and promoting behavioural change before he/she undertakes counselling with this group of high-risk clients.

**Blood safety**

There is a 90-95% chance that someone receiving blood from an HIV infected person will contract HIV. While millions of lives are saved each year through blood transfusions, in countries where a safe blood supply is not guaranteed, recipients of blood run an increased risk of HIV infection. However, this risk can be virtually prevented by a safe blood supply, and by using blood transfusions appropriately. Difficulties hindering a safe blood supply include:

- Lack of a national blood screening policy and plan;
- Lack of an organized blood transfusion service;
- Lack of safe donors or the presence of unsafe donors;
- Lack of blood screening; and
- Unnecessary or inappropriate use of blood.

**Minimizing the risk of HIV infected blood transfusions**: Regulations on blood donations, screening and transfusions are essential. Pakistan is in the process of ratifying such national regulations. It is then essential that these regulations be rigorously enforced. Three essential elements must be in place to ensure a safe blood supply:

- There must be a national blood transfusion service run on non-profit lines that is answerable to the ministry of health.
- Wherever possible, there should be a policy of excluding all paid or professional donors, but at the same time, encouraging voluntary (non-paid) donors to come back regularly. People are suitable donors only if they are considered to have a low risk of infection.
- All donated blood must be screened for HIV, as well as for hepatitis B and syphilis (and hepatitis C where possible).

**Selecting blood donors**: Paid donors very often come from the poorest sectors of society. They may be in poor health, undernourished and at risk of having infections that can be passed on through transfusions. In some places, paid donors sell blood mainly to buy drugs to inject themselves (often with shared, unsterile equipment). In addition, paid donors are more likely to give blood too often, with the result that their blood may be substandard, and the donors are likely to damage their own health.

In some countries, the use of replacement donors has also been found to be problematic. In the replacement donor system, families of people needing a transfusion are asked to donate the same quantity as that given to their relation. This blood may be used directly for the relative, or placed in the general pool. In Pakistan, the replacement donors system accounts for the largest quantity of donated blood.

The safest type of blood donor is the voluntary, unpaid donor. Such donors donate their blood for humanitarian reasons and are more likely to meet national criteria for low-risk donors. Every effort should be made to educate, motivate, recruit and retain low-risk, unpaid donors. Systems are being put in place to encourage voluntary, unpaid donations from the general public in the larger areas of Pakistan.

**Benefits of VCT in blood donor services**: A fully implemented blood donor information and counselling programme has the following potential benefits:

- Wastage of blood units collected and wasted costs from collection of HIV-infected blood would be minimized.
- Blood donor HIV prevalence would be reduced to below the national average.
- An uninfected donor pool would result.

Health care workers who are planning to start a blood screening programme with adequate client information, and pre and post HIV test counselling
should refer to the following literature: *Blood Safety and AIDS*. UNAIDS Points of View. UN AIDS Best Practice Collection, October 1997.


The following flow chart provides a visual representation of the stages to be undertaken in blood donor counselling. Figure 6 provides a flowchart of the blood donation counselling cycle.
Figure 6: FLOW CHART OF STAGES IN BLOOD DONOR COUNSELLING

Stage 1: Pre-donation information

Self-Deferral

Prevention: reinforced

Stage 2: Pre-donation counselling, Physical check and selection

Deferral/Self-Deferral

Stage 3: Blood donation and testing

Positive/Equivocal
Repeat test on new sample

Negative

Stage 4: Post donation information and/or counselling

Positive/Equivocal
Post donation counselling and/or referral

Recruit for regular donor

Health care and support services for testing, follow-up counselling and/or care
There is no guarantee that blood can be 100% free of HIV, however, with political commitment, good organization, sufficient funding and donation of blood from low-risk, voluntary, non-paid donors, the risks can be reduced to a minimum.

Counselling Strategies: Pre-test counselling for blood donors should start by providing the potential blood donor with adequate information about HIV, and how it is transmitted. This should be followed by using the same guidelines as pre-test counselling for clients requesting an HIV test (see Chapter 6). Although these two populations might be very different in terms of their risk behaviour, the same counselling protocol should apply. It cannot be assumed that blood donors are a low-risk population. However, sensitivity is required to ask some of the very personal questions related to sexual activity and injecting drug use. Questions should also be raised about previous blood donation, and whether the client has received a blood transfusion in the past. Depending on the literacy level of the person, the client can complete a checklist form (see Appendix C) him/herself which can then be given to the person drawing blood. If the client is illiterate, then the questions on the checklist must be asked in person. It is often the case that when a person is confronted by these questions, if there is any doubt about whether their behaviours might put them at risk for HIV, they select to withdraw their offer of donating blood. Although the blood is screened for HIV, such pre-test counselling is essential. Should the client be found to be HIV positive, every effort should be made to contact this person, and provide post-test counselling (see Chapter 6). If post-test counselling is not available in the blood donor clinic, the person should be referred to a setting where post-test counselling can be carried out. Contact tracing should also be carried out using the contact tracing form (see Appendix E, Partner Notification Form).

Skin piercing practices

Skin piercing practices such as male circumcision, other invasive surgery, and tattooing with un-sterile equipment infected with HIV are other important sources of HIV transmission. Counsellors should be aware of these practices and help educate the public about the risk of HIV transmission. Counsellors can play an important role in public education, and raise the awareness of using un-sterile equipment. Because it is impossible to know if instruments or needles are infected with HIV, counsellors should promote the practice of sterilization of all surgical and medical equipment. The counsellor should refer to information on universal precautions to become more familiar with this practice.

Health care workers are also at risk for HIV transmission through needle sticks and other skin piercing accidents. In addition, it is possible to contact HIV though the mucous membranes, thus any splashes to the eyes, or in the mouth with HIV infected blood should be rinsed immediately. Because it is impossible to be sure whether a patient is infected with HIV, universal precautions should be carried out in all patient care. It is beyond the scope of the counsellor to educate health care workers about universal precautions. However, the counsellor can play an important role in raising awareness about this problem. In addition, if a health care worker does report a skin piercing injury, or blood or mucous splash to the mouth or eyes, the counsellor can play an important role in pre-test and post-test counselling.

Counselling Strategies: An important role the counsellor can perform is to raise the awareness of the general public and health care workers about the potential hazard of contracting HIV through skin piercing practices or accidents. The promotion of universal precautions should also be promoted. Health care workers should be encouraged to report accidents where transmission of HIV is possible. If a health care worker reports such an accident, the counsellor should then conduct pre-test counselling. The details about sexual activity or potential injecting drug use are not as important in this instance. Instead, it is very important to write a detailed report that highlights how the accident occurred. The worker should then undergo an HIV test. It is important to remember that HIV antibodies can take from 3-6 months to be detectable in the blood, and so the health care worker should be encouraged to return for a second HIV test in 3 months’ time. The first test will be used as a baseline for a sero-negative status. Such accidents should be reported to the hospital/clinic administration. If possible, prophylactic anti-retroviral therapy should be given. The practice of universal precautions is problematic in Pakistan, and counsellors (and others) have a responsibility to raise the awareness of this problem and to promote behavioural change.
Although HIV transmission is possible in every segment of society, there are certain populations that are at particular risk. These populations include women, children, families, health care workers, long haul lorry drivers, migrant workers, commercial sex workers, homosexuals, bisexuals, and transvestites. This chapter will focus on the special needs of women, couples and families. Guidelines related to counselling for the potential HIV transmission in health care workers were addressed in Chapter 7. Counselling for other at-risk populations was addressed in Chapters 5, 6 and 7. These previous chapters addressed guidelines for effective counselling for at-risk populations, and issues related to voluntary testing and counselling.

The Vulnerability of Women

AIDS prevention campaigns often fail by women assuming that they are at low risk, or by urging prevention methods that women have little or no power to apply, such as condom use, abstinence and mutual faithfulness within a relationship. Women continue to make strides towards equality with men. However, for millions of women, this is far from reality. These women are the most vulnerable to HIV infection. In Pakistan, although movements are being made toward greater equality of women, this is still far from a reality. Women are often dependent on their husbands for the financial livelihood of themselves and their children. In addition, many women have little power or control in family affairs. This situation leads women to having very little negotiating power with their husbands, particularly when it comes to negotiation about safe sex practices and the use of condoms. Even when a woman knows that her husband has engaged in high risk practices (such as casual, unprotected sex with others, or injecting drug use), she has little negotiating power to protect herself from infection.

Women are particularly vulnerable to HIV infection for the following reasons:

Biological Vulnerability: Research shows that the risk of becoming infected with HIV during unprotected vaginal intercourse is as much as 2-4 times higher for women than men. Women are also more vulnerable to other STDs (multiplying the risk of contracting HIV 10-fold). One of the major reasons for this is that women have a bigger surface area of mucosa (the thin lining of the vagina and cervix) exposed to their partners secretions during sexual intercourse and semen infected with HIV typically contains a higher concentration of virus than a woman’s sexual secretions. Younger women are even more at risk because their immature cervix and scant vaginal secretions put up less of a barrier to HIV. Also, they are prone to vaginal mucosa lacerations. There is also evidence that women again become more vulnerable after menopause. In addition, tearing and bleeding during intercourse whether from "rough sex", or rape multiplies the risk of HIV infection. Anal intercourse (sometimes preferred because it is thought to preserve virginity, and avoids the risk of pregnancy) often tears the delicate anal tissues and provides easy access to the virus.

Social and economic vulnerability: Prevention messages urging abstinence, fidelity (faithfulness to one partner), condom use, needle exchange programs (for intravenous drug users) and encouraging and enabling people to get prompt STD treatments have all helped avoid HIV. However, for millions of women, their ability to make these decisions and to act upon them is crippled by their socio-economic circumstances. The majority of women lack economic resources, and are fearful of abandonment or violence from their male partner. Thus they have little or no control over how and when they have sex, and hence over their risk of becoming infected.
Counselling for HIV/AIDS

This vulnerability is compounded by:

- **Traditional norms and values:** In Pakistan, the majority of women are expected to stay home and raise their family. Although this is an important family value, this often places the woman at an economic disadvantage. Thus the power she has in the relationship could be reduced, and the possibility of negotiating for safer sex practices is also at risk.

- **Lack of education:** Millions of young girls are brought up with little knowledge of their reproductive system or how HIV and STDs are transmitted (and prevented).

- **Sexual customs and norms:** Typically, women are expected to leave the initiative and decision-making in sex to males whose needs and demands are expected to dominate. There is often a tolerance for a double standard in that women are blamed or abandoned for infidelity (real or suspected), while such practices are tolerated in men.

- **Lack of economic opportunities:** Failure to respect the rights of women to equal access to education and employment opportunities reinforces their dependence on men. Women commercial sex workers view sex as a "currency".

- **Lack of control in relationships:** Even when a woman suspects her partner has HIV, she often cannot risk losing his support by refusing sex, or insisting on condom use. She would be breaking the "conspiracy of silence" that surrounds extramarital sex by either partner. Although some men may agree to use condoms, others react with anger, violence and abandonment.

- **STDs and HIV:** Because STDs carry a heavy social stigma (especially for women), women tend to avoid STD clinics and treatment. Women are often socialized to accept ill health and especially "women's troubles" as their lot in life.

- **HIV and prostitution:** Prostitutes have little power to protect themselves from HIV. Women often turn to prostitution as an alternative to poverty. Many sex workers risk violence or loss of income if they request the use of condoms, however, some commercial sex workers have found ways to negotiate condom use. These sex workers wait until the client is erect, and then demand condom use. At this stage, the men usually conform.

**The Counsellor's Role in Fostering Empowerment**

Women's vulnerability comes from lack of power and control over their risk of HIV. Although counsellors cannot take on the whole role of promoting empowerment for women, they can act as an important resource and role model to others. Strategies for fostering empowerment in women include:

- **Combating Ignorance:** Promote the improvement in education for women, including education about their bodies, STDs and AIDS. Women and girls can also learn the skills to say no to unwanted or unsafe sex. Provide women-friendly services.

- **Ensuring girls and women have access to appropriate health and HIV/STD prevention and care services:** These services should be at places and times that are convenient and acceptable to them. Promote voluntary testing and counselling, and teach about condom use. Make these services easily available without embarrassment.

- **Building safer norms:** Support women's groups and community organizations in questioning behavioural traditions that have become deadly in the AIDS epidemic. Educate boys and to respect girls and women, and to engage in responsible sexual behaviour.

- **Reinforcing women's economic independence:** Encourage and strengthen existing training, education and employment opportunities for women.
Mother to Child Transmission of HIV

Mother to child transmission (MTCT) of HIV is the major means of HIV infection in children. Without preventive treatment, up to 40% of children born to HIV-positive women will be infected. Of those who are infected through MTCT, it is believed that about 2/3 are infected during pregnancy and around the time of delivery, and about 1/3 are infected through breastfeeding. Most of the transmission in pregnancy occurs at the time of labour and delivery (more than 60%). Using the most widely available tests it is not possible to tell whether a newborn infant has already been infected with HIV. The child of an infected mother may have maternal antibodies in his/her blood until 18 months of age. Therefore, testing cannot be used to help make decisions about whether or not to breastfeed the baby.

Counselling Strategies: Counsellors can play an important role in preventing HIV transmission to sexual partners and children. Certain issues are important to consider in counsellng women, couples and families. Table 4 provides a checklist for counselling pregnant women.

Counselling Women

It is often preferable for women counsellors to counsel women. It is especially important to help the woman feel safe in the counselling session. Counselling an infected woman should take into consideration how she has learned of her condition. A woman often discovers her infection by accident; sometimes after her husband, or child show symptoms of HIV infection. The first concern addressed by many women is the concern they have for their children. The counsellor should understand that the woman is dealing with two crises; the crisis of her husband or child's illness, and her own feelings and emotions. In addition, if the woman discovers that she is HIV-positive, she has the stress of disclosing this news to her partner and family. Anger, fear, and guilt are common feelings experienced by HIV-infected women (see Chapter 4 for counselling strategies to assist the woman). Even if the woman was infected through her partner, she will need considerable support when disclosing her condition to others. HIV-infected women often feel extremely lonely and isolated. Fear of social stigma may compel her to keep the condition secret. Women fear being abandoned, and deprived of the support of family, friends and community organizations. Helping the woman re-establish connections with family and other social groups is often a major task in counselling. Helping women establish peer group support can also be an important counselling strategy.

Couple and family Counselling

Couple and family counselling will depend on the HIV status of the parents and the children. Experience has shown that couples and families lead a better quality of life, access necessary resources, and support each other more if they are able to fully disclose their HIV status, and means of transmission. This disclosure can be very stressful for the family, and some families separate as a result of this disclosure. However, with support from the counsellor, such disclosure is most often very beneficial. If either of the couple is HIV-positive, then unless condoms are used, there is the risk of infecting the other partner. Counselling about planned pregnancies requires sensitivity and tact. The couple should be counselled about the risk of HIV transmission to the wife, with subsequent transmission to the child. The counsellor must be aware of these risks and provide factual information to the potential parents in a manner that is easily understood. It will then be up to the parents to make an informed decision about whether to have a child or not. Similarly, if the woman is HIV infected, the couple should be counselled about the potential risk to the baby during pregnancy, labour, delivery and through breastfeeding. It is the responsibility of the counsellor to provide this factual information about the risks of HIV transmission and then allow the potential parents to make an informed decision. If the woman is HIV-positive and is already pregnant, the counsellor can raise the issue of pregnancy termination. This type of counselling requires considerable sensitivity to the problems and needs of the couple. In addition, it is essential that the counsellor refers the couple to other necessary community resources, support groups and in particular, to medical care.

Counselling families with an HIV-infected child requires considerable sensitivity. Parents usually feel guilty about this HIV transmission and grief at the thought of losing the child. These emotions are normal and should be openly discussed and explored (see Chapter 4). Parents must be helped to deal with their own emotional reactions so that they can provide a level of stability in the home. The counsellor should provide practical advice about caring for the child in the home, or refer the family to other resources that are better equipped to help the family in this matter. An important role the counselor can
Pretest Counselling

- Patients request for HIV testing should be honoured. She has the right to ask and to be taken seriously.
- Explore patient’s HIV risk history and discuss the reasons for recommending test.
- Discuss the potential for reducing risk to the fetus if the patient turns out to be HIV positive.
- Discuss ways HIV is transmitted (anal or vaginal intercourse, blood transmission).
- Explain test limitation (3-6 months window period).
- Explain length of time until test result is available
- Review safe sex and safe IV drug practices.
- Consider psychological implications of testing including the anxiety she may feel waiting for the result.
- Does the patient have an adequate support system? Someone she feels she can talk to if the test is positive?
- Discuss the advisability of partner testing?
- Obtain informed consent for test. Verbal consent is adequate if a short explanatory note is recorded in the chart.
- A patient has the right to decline testing.

Post-test Counselling

It is imperative to give HIV test results in person and never to do so over the phone, particularly by leaving messages.

Negative Test:

- Explain test result-interpret test result (not infected up to 6 month previously).

take is to encourage the family show affection to the child, and to treat the child as normally as possible. The counsellor should also encourage the parents to tell the child about his/her condition as soon as the child is able to understand and cope with this news. This disclosure helps the child adjust to his/her condition and promotes access to other necessary resources.

Positive Test:

Necessary, first visit counselling

- Explain test result/provide reassurance about patient’s immediate safety (difference between HIV and AIDS).
- Ensure support
  - Your continued support (make a follow-up appointment)
  - Potential support of family and partners. Possible disclosure
  - Availability of community support agencies name and phone number
- If possible, review transmission modes and safer sex guidelines.

Other important counseling at first or subsequent visits. Emphasize early if poor follow-up is likely.

- Discuss health and treatment issues for the women herself.
- Review risks to fetus, potential for treatment.
- Reiterate patient’s rights to privacy and confidentiality with respect to medical information.
STRATEGIES TO INTRODUCE AND SUPPORT HIV COUNSELLING SERVICES

It is often the case that little value is placed on counselling which receives little (if any) financial support. As a result, counselling services are often fragmented, with no designated time or place for sessions. In addition, health care professionals have to fit counselling into their already overburdened work life, with little financial compensation. It is difficult for health care workers and other care professionals to value this important role when counselling is thus under-valued by policy makers and government officials. It is therefore encouraging to note that Pakistan is moving toward the introduction of HIV counselling. These counselling services will be available for people who wish voluntary testing and counselling (VCT) for an expressed issue or concern, and also to potential blood donors. It is important to note that whether the person comes to donate blood, or with an expressed desire for HIV testing, that pre-test counselling be performed for all people (see Chapter 6). However, it should also be noted that if the client refuses pre-test counselling, HIV testing should still be performed at the client’s request. Although the pretest counselling might be slightly different in the case of a person requesting an HIV test, and those coming to donate blood, the same factual information is necessary in both circumstances. The guidelines for pre-test counselling are found in Chapter 6 and the issues related to counselling and blood donation are found in Chapter 7.

In addition, all clients should be offered post-test counselling regardless of the result. Post-test counselling will be different, depending on the result, however, post-test counseling for all clients is essential to help prevent the transmission of HIV and to help people live healthier lives. Research and experience has shown that people who receive post-test counselling (regardless of the result), with adequate information (see Appendix F) are better motivated to make necessary behavioural change, access support and other resources, and live a better quality of life.

Elements for Effective VCT Services

Ideally, all health and social service workers should be trained in effective HIV counselling. Although this is a daunting task, it should be acknowledged that the more people who are aware of, and practice effective HIV counselling, the more likely will be the control of HIV transmission. Some particular strategies for consideration in the introduction and support counselling services include:

- Convincing the decision makers about the need and value of counselling services by quoting evidence of services in other communities or countries, or starting a small evaluation project in your area;
- Providing adequate financial compensation for counsellors;
- Ensuring proper selection of counselling trainees. These people should be good listeners, respected by others, motivated and resilient and have warm and caring personalities;
- Providing training workshops followed by supervised practice and ongoing training;
- Providing instrumental and psychological support to the counsellors;
- Attending to the location and time of services. The time of services should address accessibility for women, men, youth and couples. In addition, the location of the service could be broadened to include maternal and child health clinics, hospital out patient clinics, community based programs, STD and TB clinics etc. These locations could help reduce the stigma attached to an exclusive HIV or STD clinic.
• Having adequate supply of condoms (with information on use);

• Going to where the people are, eg. commercial sex workers, intravenous drug users, and other high risk populations;

• Introducing educational campaigns to increase HIV awareness, and of counselling services;

• Recruiting confidential, respectful and caring staff;

• Providing adequate referral services eg. to other counsellors, laboratory testing, support services, treatment management, maternal/child health services, STD clinics, family planning centres etc.;

• Setting up appropriate counseling standards and protocols.

Care for the Caregiver

There is considerable documentation to suggest that counsellors need ongoing support and care. Counselling requires sensitivity, courage, and an unerring trust in people to make the best decisions for themselves given adequate understanding and support. Working with people as they explore deep and personal emotions and issues can be draining. Caring for someone who is sick and dying, often in difficult circumstances with few resources can be very stressful for these counsellors. Support for the counsellors can be achieved by attending to the following:

• The provision of counselling services and other forms of support.

• Continuing education related to HIV and to counselling strategies and skills;

• Peer support for the counsellors as well as periodic peer review of their counseling skills and strategies.

Even in poorer areas where there is little financial support for counselling services, bureaucrats and policy makers should recognise the need for counsellor support. In addition, counsellors should be encouraged to seek the support they need. They should look to other counsellors as a source of support, or talk over some of their burden with their family and friends. These counsellors do not need to breech confidentiality to explore their feelings and frustrations with others. Only when counsellors are adequately cared for can they provide the necessary care and support to their clients.

References

AIDS Action: Much more than information. AHRTAG (29), June-August, 1995.

AIDS and Men who have Sex with Men. UNAIDS technical update. UNAIDS Best Practices Collection, October, 1997.


Expanding the Global Response to HIV/AIDS Through Focused Action. UNAIDS Best Practice Collection: Key Material. UN AIDS, 98.1.


HIV and Infant Feeding: A guide for health care managers and supervisors. (WHO/FRH/NUT/CHD/98.2. UNAIDS/98.4 UNCEF/PD/NUT(J)98-2)

HIV and Infant Feeding: A policy statement developed collaboratively by UNAIDS, WHO and UNICEF. (UNAIDS).

HIV policy on testing and counselling. UNAIDS 97.2

Keys to Counselling. AIDS ACTION Newsletter, (24), AHRTAG, 1994
UNAIDS/98.10-WHO/EMC/VIR/98.2-WHO/ASD/98.2).

The Female Condom and AIDS. UNAIDS Point of View. UNAIDS Best Practices Collection, April, 1998.

The Public Health Approach to STD Control

Women and AIDS: UNAIDS point of view.
(UNAIDS Best Practice Collection. October, 1997).


HIV ANITBODY CONSENT FORM

Before taking this test I understand:

- That the Human Immunodeficiency Virus (HIV) is responsible for the disease AIDS (Acquired Immune Deficiency Syndrome)
- This test is to detect antibodies, which the body forms if it has been infected by the AIDS Virus (HIV).
- That it may require up to 6 months after infection with the virus for antibodies to show in the test.
- THIS ANTIBODY TEST IS NOT DIAGNOSTIC OF THE DISEASE AIDS

I have read the "HIV Antibody Testing" brochure, my questions about the test have been answered and I consent to return in person to receive my test results from one of the healthcare workers/counsellors or physicians in the clinic.

I understand the significance of this test and take it voluntarily.

__________________________      __________________________
Name           Signature
__________________________      __________________________
Address         Telephone Number
__________________________      __________________________
Name of Witness         Signature of Witness
__________________________      __________________________
Name of Witness         Signature of Witness

I have received my HIV Antibody Test results. I want my tests forwarded to my physician, named below.

__________________________      __________________________
Name            Witness
__________________________      __________________________
Signature of Client         Signature of Witness

__________________________      __________________________
Name of Physician          Address
__________________________      __________________________
Telephone Number          Postal Code

Counselling for HIV/AIDS  59
SUGGESTED OPEN-ENDED QUESTIONS FOR HIV COUNSELLING

INTRODUCTION/RISK ASSESSMENT

- How are you today?
- Tell me a little about why you came in.
- What brings you here today/tonight?
- Who do you think will know you were here today?
- What does confidentiality mean to you?
- When were you last tested?
- Why do you want to be tested?
- What makes you think you should take the test?
- What has happened that makes you feel you need to be tested?
- What role did a friend or a sex partner play in you coming in for the test?
- What do you know about how AIDS or HIV is transmitted?
- Tell me what you know about the virus that causes AIDS
- Tell me what you know about the antibody test for HIV.
- What do you know about the test for HIV?
- How do you think the virus is passed from one person to another?
- Tell me what else you know about HIV.
- What does putting yourself at risk mean to you?
- How has your health been?
- When’s the last time you were treated for a sexually transmitted disease?
- What types of sex do you have?
- How many different people do you have sex with?
- What medications are you taking?
- How much do you know about the risk factors or lifestyles of the people you are having sex with?
- How many people are they having sex with?
- How often do they shoot up drugs or take other illicit drugs?
- When was the last time you had unprotected sex?
- What does sex mean to you?
- How sure are you about whether or not any of your sex partners are infected?
- How would you describe your risk of being exposed

REDUCE RISK

- Tell me what you do now to reduce your risk of infection?
- How often have you used condoms in the past?
- What kind of problems do you have using condoms?
- What do you believe in safe sex?
- How do you think you will protect yourself from getting this infection?
- When’s the last time you used condoms?
- Tell me what kind of condoms to get and how to use them.
- How would your sexual behaviour have to change to stay safe?
- What do you do for birth control?
- What do you think you can do to avoid HIV infection?
- What are you going to do to staying safe?
- How often do you use a condom with your steady sex partner?
- How do you normally go about discussing condoms with a potential sex partner?
- How successful have you been in getting partners to use condoms?
• When do you have the most difficulty in discussing condoms with your partners?

ASSESS COPING SKILLS/EFFECT A CLEAR DECISION/CONCLUSION

• How will the waiting time be for you?
• What are some things you can do while waiting for the test results?
• Who can you talk to about this while you are waiting for your test results?
• What do you expect the test result to be?
• What would a negative test mean to you?"
• What do you think you will do if your test is negative?
• Who will you tell about the test results?
• What does a positive test mean to you?
• What change will you make if your test result is positive?
• What concerns do you have about confidentiality?
• What does anonymous testing mean to you?
• How would you prefer to have the test done?
• How would your drug use practices have to change to stay safe?
• When are you coming back for your test result?
• What else I can do for you?
• What questions or concerns do you have?
• What problems will you have telling your spouse or steady sex partner(s) about your infection?
• What steps can you take regarding your drug use to improve your chances of remaining free of the virus?
# PRE-TEST COUNSELLING VISIT

Date:__________________________ Previous HIV test: ________________ (date)__________________

Patient's initials: ___________________________ ( ) M ( ) F ____________________

(result)____________________________________

D.O.B. _______________________ Identification No. ________________ Ethnic Group_________

## PRESENT HEALTH INFORMATION:

<table>
<thead>
<tr>
<th>General Health</th>
<th>Unexplained Changes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Present Health Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td>Blood transfusion</td>
</tr>
<tr>
<td>MSM</td>
<td>Blood Product</td>
</tr>
<tr>
<td>CSW</td>
<td>Occupational</td>
</tr>
<tr>
<td>Exposure</td>
<td>From Endemic Area</td>
</tr>
<tr>
<td>HIV+/AIDS</td>
<td></td>
</tr>
</tbody>
</table>

**IDU**

Date Last Shared: ________________

Drugs Used: ________________

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Date Last Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sexually Active**

<table>
<thead>
<tr>
<th>Vaginal Sex</th>
<th>Oral Sex</th>
<th>Sex Toys</th>
<th>Condoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>A S N</td>
</tr>
<tr>
<td></td>
<td># partners last 6 months</td>
<td># partners last 2 months</td>
<td># partners life</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shared razor blades</th>
<th>Tooth brush</th>
<th>Nail files</th>
<th>Hepatitis B bld work</th>
<th>STD Check UP</th>
<th>Hepatitis B Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td>Date Last Risk</td>
<td>YES</td>
<td>NO</td>
<td>DATE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## COUNSELLING HAS TAKEN PLACE REGARDING:

( ) Content of Brochure
( ) Window Period
( ) Transmission
( ) Safe sex/Condom Use
( ) Interpretation of Result
( ) Follow Up Counselling Suggested
( ) IV Needle Cleaning

Risk Not Covered By Today's Tests

Recommended Date of Test

Support system In Event Test Reactive/Positive
Have you thought of what you would do/how feel if your test was positive?
If positive you will need to develop a personal/community/medical support system

* Code: MSM-men sex men  *CSW- commercial sex worker  * IDU-injecting drug user
POST TEST COUNSELLING VISIT

Date:_____________________     Result:________________________

Counselling has taken place regarding:

() Test Result       () Lifestyle Modifications
() Interpretation of Result () Safe Sex
() Repeat Testing     () Pregnancy
() Infectivity       () Blood/Organ Donations
() Informing Health Care Attendant () By Self
() Notification of Sexual Partners () By Health Care Worker
If Positive +*

Date of Follow-up Appointments:_______________________________________________________

Referrals:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Comments:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

* IF HIV POSITIVE – Specify in notes
APPENDIX-E

PARTNER NOTIFICATION FORM

You have tested positive (reactive) for antibodies to HIV. You can help prevent HIV from being transmitted to others by making sure that your past and present partners are notified that they may have had a contact with HIV. This applies to all sexual partners with whom you have had unprotected sex (anal, vaginal or oral sex without using a latex condom) as well as anyone with whom you may have shared needles or syringes. If you know approximately when you were infected, notify all partners you have had since that date. If you do not know when you were infected, discuss notification with you counsellor or health care worker.

YOUR PARTNERS CAN BE NOTIFIED BY:

- Yourself, in person (with or without the assistance of your health care worker, or HIV counsellor), by telephone or by letter.
- ANONYMOUSLY, by filling out this Partner Notification Form.

Mail or deliver this form to:____________________

OR

Mail or deliver this form to your local health unit.

You may decide to notify some partners personally, and use this form for others. Your confidentiality will be protected as there is no need for you to put your name on this form.

YOU CAN PREPARE FOR PARTNER NOTIFICATION BY:

- Emotionally preparing yourself by anticipating partner responses.
- Seeking assistance and advice from someone knowledgeable about HIV infection.
- Notifying in a confidential, safe setting, free from interruptions.
- Notifying all partners as soon as possible.
- Reminding partners that being HIV positive is not a diagnosis of AIDS.
- Providing information brochures and referral services names and numbers.

Encourage partners to reduce their risks of HIV transmission and to access information, counselling and possible testing through STD control clinic, health unit/Clinic, doctor, blood donor centre, or other HIV testing facilities.

<table>
<thead>
<tr>
<th>NAME</th>
<th>SEX</th>
<th>AGE</th>
<th>ADDRESS</th>
<th>PHONE NUMBER</th>
<th>DATE OF MOST RECENT SEX/BLOOD CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CLIENT INFORMATION

GUIDELINES FOR SOMEONE WHO IS HIV POSITIVE

WHAT DOES BEING HIV POSITIVE MEAN?

Your blood shows antibodies to HIV (human immunodeficiency virus). This means that you are carrying this virus and can pass HIV on to others through sexual and/or blood contact and through breast milk. This is called being reactive to HIV and is sometimes referred to as being HIV positive. Being HIV positive does not mean that you have the disease AIDS.

WHAT IS THE NEXT STEP?

The management of HIV changed in 1996. Currently all newly diagnosed HIV positive persons are encouraged to get a medical assessment done by the doctor. In some places, a viral load test can be done which will measure the amount of HIV in your blood. This test along with other blood tests and a complete medical examination will aid your doctor in recommending whether the time is right for you to be considering treatment. Treatment is expensive, and unfortunately, not available to everyone. Testing for tuberculosis is recommended when the person is HIV positive. There are several vaccinations for other communicable diseases, which should be considered at this time. It is important to have a physician who will work with you to coordinate your case.

Additional confidential support (both medical and emotional) is available from your local health unit.

ARE THERE WAYS TO PREVENT THE SPREAD OF THIS INFECTION?..YES!

Practice Safer Sex

Avoid unprotected anal, vaginal and oral sex. Always use latex condoms. (Latex condom when properly used, significantly reduces transmission of sexually transmitted disease including HIV)

Use unlubricated condoms for oral sex. Plastic wrap and dental dams or latex gloves can be used as a barrier from vaginal secretions and blood when performing oral sex on a woman.

HIV is transmitted by exposure to infected semen, vaginal secretions and blood. The risk of passing on HIV to a sexual partner increases if the partner has open sores, cuts, inflamed or bleeding membranes, herpes lesions or other sexually transmitted diseases.

You won't infect others by touching or hugging. If you have questions about the kind of contact that are safe ask a health care worker or HIV counsellor.

ALSO

Consult with your doctor about pregnancy. If you are pregnant, inquire about medications that might be available to decrease the risk of HIV transmission from you to your unborn baby.

Do not share your needle or syringes if you inject drugs. Call your local health unit for information on needle exchanges and on treatment programs.

Do not donate blood, sperm, tissue, bone marrow, organs or breast milk. If you have been a donor in the past, please advise your doctor so that the agencies receiving the donations can be contacted.

Advise health and dental caregivers to take blood and body fluid precautions or tell them you have tested positive for HIV.

NOTIFY ANY PARTNERS THAT YOU HAVE HAD UNPROTECTED SEX WITH OR ANY PERSONS WHO YOU HAVE SHARED A NEEDLE WITH. TELL THEM THEY MAY BE HAVE BEEN EXPOSED TO HIV AND SHOULD CONSIDER HAVING AN HIV ANTIBODY TEST.
LOVING CAREFULLY

PREVENTION: HOW DO I AVOID GETTING A SEXUALLY TRANSMITTED DISEASE?

There are two ways to avoid getting infected by a sexually transmitted disease.

1. ABSTINENCE This means choosing not to have sexual intercourse. You can still share a very loving and caring relationship with someone without having sex.

2. CONDOMS If you are sexually active you need to use a latex condom correctly every time you have intercourse. It only takes once to catch a disease or get pregnant.

AIDS is caused by the HIV virus, which attacks the body's immune system making it susceptible to common infections and unusual cancers. The AIDS virus is present in blood, semen and vaginal secretions. It can be spread by:

- Sexual contact with an infected person
- Sharing contaminated needles and syringes
- An infected mother to infant eg. at birth or by breast-feeding.

Symptoms: Persistent unexplained fever, night sweats, weight loss, diarrhoea, swollen glands, extreme fatigue, and skin rashes. Unfortunately the person is contagious after becoming infected with the disease, long before the symptoms occur.

Complications: Kaposi's Sarcoma and other forms of cancer, pneumonia, blindness, deteriorating mental state, overwhelming infections.

Treatment: At this time there is no cure for AIDS. It is critical to take protective measures, eg. using latex condoms, to prevent infection by this virus.

Steps To Take If You are HIV Positive

If you tested positive on the HIV antibody test, this newsletter is for you. It will tell you what you can do to slow down the virus and protect your health and the health of others. Testing positive means that you have been infected with HIV, the virus that causes AIDS. People who are HIV-positive may develop AIDS in the future.

The most important steps are:

- Getting emotional support.
- Getting good medical care.
- Keeping healthy habits.

Emotional Support

Emotional support is the help that you receive from other people. If you get emotional support, you won't feel so alone dealing with HIV.

When you find out that you are HIV-positive, it can be very tough. You may feel lonely, angry, depressed, or afraid of getting sick. These are very common feelings among people who test positive.

Some people who are HIV-positive discuss their feelings with their friends, family, or lovers. Others prefer to see a personal counsellor and get individual support.

Another option is to join a support group or to start one. A support group lets you talk to other people who are facing the same issues.

Emotional support is especially helpful in the first few months after getting your test results. Once you sort out some of your feelings, you can start thinking about what you can do to keep healthy.

Some people who test positive feel the need to start doing something right away to stop the virus. Others may feel there is nothing they can do against HIV infection. The truth is there is a lot that can be done to improve your chances of staying healthy. Most people who are HIV-positive live with no symptoms for many years after being infected. Some of them have been healthy for more than eleven years.
Medical Care

Medical care is very important in finding out whether the virus has caused any damage to your body. You may feel completely healthy now. However, HIV could already be hurting your immune system.

Your immune system helps you fight diseases. HIV destroys a part of your immune system. If this happens, your body is open to attack from many diseases.

A doctor can check how healthy you are and help you make decisions about treatment. Sometimes you won't need to see a doctor. Some hospitals and clinics have nurses and other medical persons who can work with you. The first step is to figure out what medical care you can get.

Once You Have a Doctor---

You and your doctor will need to get a general picture of how healthy you are. The goals are:

- To understand what effect HIV has had on your immune system. Some lab tests will give your doctor information about how well your immune system is working. The most common test available is the T-helper cell count.

- To know if you have been exposed to other diseases that could become problems in the future. Syphilis, tuberculosis and hepatitis-B or C are some examples.

Keeping Healthy Habits

There are some habits that may help your body stay healthy.

- Eating a balanced diet
- Getting plenty of sleep every night
- Getting regular exercise.

Some clinics and hospitals have staff who can help you choose good eating habits. If you are having trouble sleeping, talk to a doctor or counsellor.

Habits that are not good for your health include:

- Smoking
- Drinking alcohol
- Taking or shooting drugs.

If you have problems with alcohol or drugs, you can seek help from a treatment programme or support group.

There is no way to tell you what changes will work for you. Changing habits is a very personal decision. For example, some people can stop drinking alcohol or taking drugs altogether. Some people can cut down how much they drink or use drugs. For others, making any change is very hard and stressful. You will need to decide for yourself what habits you can change, and how you will change them.

Drug Use---

If you shoot drugs, never share your needles. If you have to share a needle, clean it first with bleach. Cleaning your needles protects both your partners and you. HIV, hepatitis-B & C and other diseases can be transmitted through dirty needles.

If you use other drugs, remember that they can alter your mood and might cause you to start taking risks that could harm your health. This includes having unsafe sex.

If you do inject drugs and cannot get a clean needle and syringe each time, follow these important steps:

To clean your needle, fill it with bleach and squirt it out. Do this again. Then fill it with water and squirt it out. Do this again.

Having Sex---

If you have sex and are HIV-positive, you need to protect yourself and others by always having safe sex. Safe sex means not letting your blood, semen or vaginal fluids get inside your partner. The safest form of sex is with a condom. Using a new condom each time, and disposing of the used one.

When you have safe sex, you keep your sexual partners from getting infected. Safe sex also keeps you from getting re-infected with HIV and from catching other sexually transmitted
diseases. In other words, safe sex protects both you and your partner. The best way to have safe sex is to use a condom. If you have any questions about how to have safe sex call your local health care worker.

If you need help telling a sexual partner that you are HIV positive, talk to a counsellor, or health care worker.

Some Final Words
Starting some of these steps will take time and energy. However, you can get a gain a lot from these changes. Protecting your health and the health of others can give you a sense of control over HIV disease and can extend your life.
Participants of the Counselling for HIV/AIDS

Facilitator:

Dr Aftab Asif
Assistant Professor of Psychiatry,
King Edward Medical College,
Lahore

Participants:

Dr Rizwan Taj
Associate Professor of Psychiatry,
Pakistan Institute of Medical Sciences
Islamabad

Dr. Laeeq Mirza
Clinical Psychologist,
Shifa International Hospital,
Islamabad

Dr. Bushra Anwer
Reproductive Health Coordinator,
Family Planning Association of Pakistan,
Lahore

Dr. Ali Gauhar Durrani
Provincial Programme Manager,
NWFP AIDS Control Programme,
Peshawar

Ms. Nosheen Khan Rehman
Professor/Director Centre for Clinical Psychology,
Punjab University,
Lahore

Dr Khawja Zaki Hasan
Professor of Psychiatry,
Jinnah Medical College,
Karachi

Dr. Musarat Hussain
Professor of Psychiatry,
Jinnah Post Graduate Medical Centre,
Karachi

Dr. Riaz Bhatti
Professor of Psychiatry,
Fatima Jinnah Medical College
Lahore

Dr. Nousheen Rahman
Director Clinical Psychology
University of the Punjab
Lahore

Ms. Raheela Dawood Khan
Clinical Psychologist,
Rawalpindi General Hospital
Rawalpindi.
Participants of the workshops to Pre-test the "Guidelines on Counselling for HIV/AIDS"

**Facilitator:** Dr. Aftab Asif, Assistant Professor, Department of Psychiatry, Mayo Hospital Lahore.

**List of the Participants**

**Sindh:**

1. Dr. Mumtaz Qazi
2. Dr. Quttub-ud-din
3. Dr. Agha Nadir Ali
4. Dr. Suresh Kumar
5. Dr. Amanullah Khan
6. Dr. DeedarAli
7. Dr. Mahreen Nazar
8. Ms. Musarrat Parveen
9. Dr. Naseer A. Bafoch

**Balochistan:**

1. Dr. Nadeem Samad Sheikh
2. Mr. S. Oamaruddin
3. Dr. Abdul Malik
4. Dr. Abdul Mannan
5. Dr. Raft ushan Ahmed
6. Dr. M.Ashraf
7. Dr. Nadira Khan
8. Ms. Raheela Durrani

**N.W.F.P.**

1. Dr. Ahmed Ali
2. Ms. Nighat Kamdar
3. Mr. Adrian McGee
4. Dr. Iqbal Hussain
5. Dr. Mussarat Khalid
6. Dr. Ayub Khan

**Punjab:**

1. Dr. Ali Razzaq
2. Ms. Shazia Hassan
3. Dr. Mahmood Akhtar
4. Mr. Arastus Attarad
5. Dr. Talat Naheed
6. Dr. M. Ashfaq

---

**Medical Officer, Juvenile Jail, Karachi**
95-B, Gulshan-e-Faisal, 15* Street, Bath Island, Karachi

**Incharge STD Clinic, Surgical OPD, Civil Hospital, Karachi**
C-13, Jumani Center Garden, East Karachi

**Clinical Psychologist, D-I, 1st Floor Court View Apartments, Sindh Assembly Court Road, Karachi**
66-A, Moria Khan Goth, Airport, Karachi

**Sr. Surgeon, Sindh Services Hospital, M.A. Jinnah Road, Karachi.**
B-26, Noman Heaven, Gulistan-e-Johar, Karachi.

**Medical Officer, Juvenile Jail, Karachi**

**Provincial Programme Manager, Blood Transfusion Services.**
DARES International, 15- Kasi Plaza Phase II, Zarghoon Road, Quetta

**Psychiatrist, Bolan Medical College Quetta**

**Psychiatrist, DHO Hospital Pishin, Balochistan.**
c/o Provincial Programme Manager AIDS, Balochistan.

**Pathologist, Fatima Jinnah General & Chest Hospital, Quetta**
House No. 3, GOR Colony, Quetta

**Room No. 60, Third Floor, Ahmed Complex, Dr. Bano Road Quetta**

**Medical Officer Blood Bank, Lady Reading Hospital, Peshawar**

**Medical Officer Blood Bank, Lady Reading Hospital, Peshawar**

**Medical Officer Blood Bank, Lady Reading Hospital, Peshawar**

**Medical Officer Blood Bank, Lady Reading Hospital, Peshawar**

**Medical Officer Blood Bank, Lady Reading Hospital, Peshawar**

**Medical Officer Blood Bank, Lady Reading Hospital, Peshawar**

**AIDS Coordinator, New Jamrud Road, Bara Khyber Agency.**

**Associate Professor Medicine, KEMC, Lahore**

**Consultant Physician, Medical Specialist Unit, Services Hospital Lahore**

---

Counselling for HIV/AIDS 71
List of the HIV/ AIDS Surveillance Centres

FEDERAL AREAS

2. Federal Government Services Hospital, Islamabad.
3. Pakistan Institute of Medical Sciences, Islamabad.
4. DHO Hospital, Skardu.
5. DHO Hospital, Gilgit.

PUNJAB

6. Armed Forces Institute of Pathology, Rawalpindi.
7. T.B. Centre, Rawalpindi.
8. The department of microbiology, Shaikh Zayed Hospital, Lahore.
9. The department of Pathology, Holy Family Hospital, Rawalpindi.
10. The department of Pathology, Rawalpindi Medical College, Rawalpindi.
11. Institute of Punjab Blood Transfusion Services, Lahore.
12. The department of Pathology, College of Community Medicine, Lahore.
13. The department of Pathology, Services Hospital, Lahore.
14. The Medical Superintendent, DHQ Hospital, Dera Ghazi Khan.
15. The Medical Superintendent, DHO Hospital, Chakwal.
16. The Medical Superintendent, B.V. Hospital, Bahawalpur.
17. The Department of Pathology, Nishter Medical College, Multan.
18. Sanitarium Hospital, Murree.
20. Government Seamen’s Dispensary Port Health Department, Karachi.
21. AIDS Control Programme Services Hospital Indoor Block, MA. Jinnah Road, Karachi.
22. Institute of Skin Diseases, Preedy Street Regal Chowk Sadar, Karachi.
23. Liyari General Hospital, Liyari, Karachi.
24. The department of Pathology, Peoples Medical College Nawabshah.
25. The department of pathology, Chandka Medical College, Larkana.
26. Civil Hospital, Mirpur Khas.
27. The department of pathology, Liaquat Medical College, Jamshoro.
28. Civil Hospital, Sukkur.
29. The department of Pathology, Lady reading Hospital, Peshawar.
30. The department of Pathology, Khyber Medical College, Peshawar.
31. The department of Pathology, Ayub Medical College, Abbottabad.
32. DHQ Hospital Saidu Sharif.
33. DHQ Hospital, D.I. Khan.
34. DHO Hospital Kohat.
35. DHQ Hospital Mardan.
36. The department of pathology, Civil Hospital, Quetta.
37. Fatima Jinnah General & Chest Hospital, Quetta.
38. DHQ Hospital Turbat.
39. DHQ Hospital D.M Jamali.
40. DHQ Hospital Sibi.
41. DHQ Hospital Lorali.
42. DHQ Hospital Khuzdar.
43. DHQ Hospital, Gwadar.
44. The department of Pathology (AJK), C.M.H, Muzaffarabad.
45. The department of Pathology D.H.Q. Hospital, Mirpur,(AJK).
About the Co-author:

Dr. Aftab Asif, co-author of the national guidelines on “HIV Counseling” is presently serving as assistant Professor of Psychiatry at the King Edward Medical College Lahore. He graduated from the same college in 1987. In 1990 he left for England and worked in various specialties of Psychiatry under the training scheme. He did his MRC Psych from UK in 1992.

Dr. Aftab has almost 10 years experience of practice in the work field. In his present assignment at Mayo Hospital Lahore, he is actively involved in psychiatric training both at the undergraduate as well as postgraduate levels. Apart from medical professionals, his trainees also include psychologists and clinical psychiatric nurses.

The co-author has special interest in the field of counseling for HIV/AIDS and received specialized trainings both at national and international levels. He is associated with HIV counseling since 1996 and has also been involved in the national sero-prevalence survey on HIV/AIDS conducted by the National AIDS Control Programme Pakistan.
This Publication is available from:

National Programme Manager
National AIDS Control Programme
National Institute of Health,
Islamabad.
Ph: 051-9255096 – 9255241
Fax: 051-9255214

Provincial Programme Manager (AIDS)
AIDS Control Programme
Sindh Services, Hospital, M.A. Jinnah Road,
Sindh – Karachi
Ph: 021-7775959
Fax: 021-7771753

Provincial Programme Manager (AIDS)
AIDS Control Programme
Directorate General Health Services,
Punjab – Lahore.
Ph: 042 – 9200987
Fax: 042-92011142

Provincial Programme Manager (AIDS)
AIDS Control Programme
Eastern Bypass
Near Fatima Jinnah General & Chest Hospital,
Quetta – Balochistan.
Ph: & Fax: 081-854182

Provincial Programme Manager (AIDS)
AIDS Control Programme
Directorate General Health Services,
NWFP, Peshawar.
Ph: 091-921083 (Exc) 9210186 – 97
Fax: 091 – 9210239

Programme Manager
AIDS Control Programme
District Headquarter Hospital,
Gilgit – Northern Areas,
Ph: 0572 – 3690
Fax: 0572 – 2500

Programme Manager
AIDS Control Programme,
Directorate General Health Services,
Muzaffarabad – AJK
Ph: 058810 – 43030
Fax: 058810 - 49114