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SOURCE BOOK FOR HIV/AIDS COUNSELLING TRAINING

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Preface

This Source Book contains essential information for the training of HIV/AIDS counsellors in developing countries and is intended for use as a resource by those conducting such training. It is also designed as a reference book and provides information to help build the skills and expand the scope of those who already provide HIV/AIDS counselling.

HIV/AIDS counselling is recommended for people being tested for HIV (pre-testing or post-testing, whether or not they are infected); for those with HIV/AIDS and their partners; for people experiencing difficulties as a result of HIV infection; and those seeking help because of past or current risk behaviour. The development of counselling services will depend on the human and financial resources available in each country to respond to the AIDS pandemic.

This book is geared to health and social workers who provide HIV/AIDS counselling as part of their regular work, as well as specialist counsellors. The term "counsellor" is used to denote not only formal health-care providers, but all who provide counselling. The term "counsellor", therefore, is not meant to imply a particular professional group. Counsellors include nurses, midwives, health and social workers, physicians, teachers and religious workers.

It is assumed that those who use this book will have at least a secondary school education. However, experienced trainers can modify the material to suit those with other educational backgrounds. Thus, this material can be used to train less educated volunteers and members of self-help groups who might provide useful, ongoing emotional support to people living with HIV/AIDS and their families.

Counselling is a vital component of HIV/AIDS care and a fundamental part of good clinical management. It is also an important vehicle for the prevention of further transmission. The implementation of counselling and the specific programmes designed to deliver these services may vary greatly in different areas of the world. Therefore, users of this Source Book are expected to extract sections and to adapt them to their local training needs. Trainers can prepare their own materials (e.g. overhead transparencies and flip charts) according to their own training methodology. This Source Book is <u>not</u> a manual and thus does not contain instructions on how to conduct training sessions.

The training of HIV/AIDS counsellors often involves training workshops which should enable participants to develop skills through activities such as role-play, analysis of case studies, small group discussions and problem-solving. Training should also include opportunities for trainees to work with actual clients while under the supervision of experienced counsellors. Regular supervision and support will help the trainees to sharpen their skills.

Before initiating counselling training programmes, trainers should clearly identify the role that counselling is expected to play in the care and prevention of HIV/AIDS. They should select the sites and facilities where counselling will be provided. Staff with the appropriate professional background and positive attitude would then be selected for counselling training at these sites.

After the training period is completed, efforts should be made to educate other health and social workers about the purpose and availability of counselling. Without being aware of the importance of counselling, other health workers will not refer clients to the newly trained counsellors, nor will administrative support be provided.

This Source Book covers the nature of HIV/AIDS counselling, the psychosocial and cultural aspects of counselling, the counselling process, and counselling skills and resources. It also deals with specific counselling situations, such as pre-test and post-test counselling and counselling for women, families and children.

Ten appendices cover specific guidelines for clients and for counsellor trainees, for instance, on how to live positively with AIDS, taking the client's history and facts about HIV/AIDS. These appendices can be photocopied and handed out to counsellor trainees or other health and social workers, as well as to literate individual clients.

The preparation of the Source Book has involved collaboration with many experts in HIV/AIDS counselling and training. It has been used in over 35 national and regional counselling training workshops organized by WHO's Global Programme on AIDS (GPA) involving over 1300 participants from 120 countries.

Relevant materials available from WHO's Global Programme on AIDS are listed at the back of this book.

Chapter 1

The nature of HIV/AIDS counselling

Why is HIV/AIDS counselling necessary?

Up until now, only a small percentage of those with HIV/AIDS have had access to reliable counselling services. However, HIV/AIDS counselling is important because infection with HIV is lifelong. During the course of the infection, a broad range of physical, social and psychological needs and problems are likely to be experienced. These are not necessarily constant, and will progressively become more serious and difficult to handle.

The changing nature of these needs imposes a variety of psychological and emotional strains on individuals and those closest to them. Dealing with HIV disease also involves direct and indirect financial costs, particularly when economic productivity is affected by illness. Much of the stress experienced by people infected with HIV may reflect underlying anxieties about economic independence and family obligations. Counselling can help individuals, their families and in turn the communities in which they live to cope with these problems.

Counselling also provides the support needed to bring about and sustain changes in risk behaviour. Knowledge alone is not sufficient to reduce an individual's resistance to change. Through counselling, the client is able to find new, and perhaps different, approaches to safer sex and responsible social relationships. Behavioural change can prevent a person from acquiring HIV infection or transmitting it to others.

Living with HIV infection or AIDS does not mean living in spite of HIV. Counselling helps individuals to actively deal with their problems in order to lead more fulfilling lives. They are able to take back control over their own lives by learning to solve their own problems and make their own decisions. (See Appendix I, "Living Positively with AIDS".)

What is HIV/AIDS counselling?

HIV/AIDS counselling is a dialogue between a client and a care provider aimed at enabling the client to cope with stress and to take personal decisions relating 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 HIV/AIDS counselling services 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 formal and informal, 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 needs of the individual and the family affected by or worried about HIV/AIDS.

HIV/AIDS counselling has two main goals:

(1) to give psychosocial **support** to those whose lives have been affected by HIV; and

(2) to **prevent** HIV infection and its transmission to other people.

These goals are achieved by:

- providing clients with information on HIV/AIDS (e.g. means of transmission, prevention and testing);
- helping the infected individual, family and friends to handle possible emotional reactions to HIV/AIDS (e.g. anger, fear, denial);
- discussing courses of action adapted to clients' needs and circumstances; and
- encouraging change when needed for the prevention or control of infection (e.g. through protected or safer sex).

The psychosocial support provided by counselling strengthens the sense of individual responsibility needed to accept new information and change lifestyles. Counselling helps people to define for themselves the nature of the problems that they are facing. Then they can make realistic decisions about what they can do to reduce the impact of these problems on themselves and their family and friends. Helping people to achieve the confidence to make lifestyle changes is an integral part of the counselling relationship.

The techniques used in counselling may vary from country to country. They may even vary within countries, depending on the background of the people being counselled and the type of health or social services locally available. Effective counselling need not follow any set pattern or approach. It should certainly not be restricted to a clinic or a structured doctor-patient situation.

Counselling, nevertheless, involves much more than an occasional informal discussion. The need for continued support and help with problem-solving is a common feature of most HIV-related situations and should be a key aspect of most counselling relationships.

Who is HIV/AIDS counselling for?

HIV/AIDS counselling is for individuals, couples, families and groups, referred to as "clients" throughout this Source Book. This type of counselling is specifically designed for:

- people being tested for HIV (pre-test or post-test, whether or not they are infected);
- those with HIV/AIDS and their partners;
- people experiencing difficulties with issues such as employment, housing, and finances as a result of HIV infection; and
- those seeking help because of past or current risk behaviour.

All sexually active people, in all countries of the world, need to be aware that unprotected sexual intercourse carries a certain risk of HIV transmission. In any society, a variety of individuals and groups may be more or less at risk, depending on their situation, their vulnerability and their behaviour. In areas of high prevalence, all sexually active people are at risk and any act of unprotected intercourse may be "risky", even with a regular partner or spouse. In all areas, certain individuals and groups may be *particularly* at risk. 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; and
- recipients of unsafe blood, blood products and donated organs.

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 other people may be involved in an HIV/AIDS counselling session:

- 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;
- members of a support group of individuals affected by HIV/AIDS;
- other resource persons, such as clinicians.

Counselling is needed by people who are at risk of HIV infection but are not known to be infected (see above). Some of them may already recognize that they are at risk; others will be unaware of the risk involved in their behaviours. In these cases, the counsellor discusses risk behaviours and reviews ways of changing them.

The counsellor should also assess the degree to which people close to the client should or can be involved, and whether or not they will support the client's desire to prevent infection. For example, where a culture places value on single men having multiple sexual partners, they may experience pressure from friends to act accordingly. Finding alternative social support may then be an important counselling task. Support groups are an excellent means of reinforcing motivation to resist social pressure and change behaviour.

If there has been risk behaviour, and testing facilities are available, the question of testing should be discussed (see "Antibody Testing", Chapter 5).

Who should provide counselling?

A wide range of people may play a role in the provision of HIV/AIDS counselling services. They may include:

- nurses, social workers and other care-providers who have been specially trained in HIV/AIDS counselling and who may be either part-time or full-time providers of counselling services at facilities in their country. Some of these trained individuals may also act as "focal points" for counselling services in their country, province or district;

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

- religious workers and other community-based workers whose work consistently entails the appropriate handling of confidential information and emotional issues;

- community members, and members of AIDS support organizations and people living with HIV/AIDS.

The appropriate roles for each of the above categories of care-giver will vary greatly from setting to setting and so will their training.

Where can counselling be provided?

HIV/AIDS counselling can take place in settings such as wards in hospitals, centres for sexually transmitted diseases, voluntary counselling and testing centres, antenatal and postpartum clinics, family planning and maternal and child health clinics, blood donation centres and sites, community health centres, schools, churches, outpatient clinics, and all health outreach or community-based programmes.

Regardless of the existing HIV prevalence in a country or region, 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 (linked HIV testing), e.g. research sites and blood donation sites.

In countries, or in defined geographical areas within a country, where HIV prevalence is high, HIV/AIDS counselling services should **also** be available at the following sites: community sites where ongoing support is provided to those affected by HIV/AIDS; health clinics at the workplace; and independent sites where voluntary counselling and testing can be sought.

Each of these settings will call for different responses from the counsellor. Each will influence responses from those being interviewed. For example, trying to ask questions about sensitive personal topics in a crowded clinic waiting-room obviously calls for an approach quite different from asking the same questions in private. So, although HIV/AIDS counselling can take place almost anywhere, privacy is an important consideration.

How are counselling and health education related?

HIV/AIDS counselling and HIV/AIDS 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 receivers before communicating.

HIV/AIDS counselling is, however, a confidential communication that is provided in reaction to the needs of the client and that provides emotional support in order to assist individuals and families who may have HIV-related problems and worries.

HIV/AIDS education, on the other hand, is a communication that is not confidential, is mainly instructive in nature and is designed to meet desirable public health needs and provides information and discussion in order to achieve these public health needs, i.e. to prevent HIV transmission, to discourage discrimination and to enable care to be provided for those affected.

The basic skill area that underpins HIV/AIDS counselling, therefore, is that of personalized communication. For example, HIV/AIDS counselling makes extensive use of one-to-one communication skills and, in this regard, relies heavily upon conversational skills, especially listening skills (see "Counselling Skills", Chapter 4).

How is HIV/AIDS counselling integrated into other services?

Since HIV/AIDS counselling is a labour-intensive activity, it will consume a significant portion of the already overstretched time of health or social workers. Service planners will need to develop strategies for integrating this new service into existing ones so that counselling is not seen as an extra burden, but rather as a support to other services. (For specific strategies on how to integrate HIV/AIDS counselling into other services, please refer to *Guidelines for implementing HIV/AIDS counselling,* in preparation.)

SUMMARY

HIV/AIDS counselling is aimed at providing psychosocial support and preventing HIV infection. Psychosocial support is necessary because a diagnosis of HIV infection confronts people with a host of emotional and/or practical problems.

Counselling is aimed at those with HIV/AIDS, their partners and families, people undergoing HIV testing and people worried about their risk of HIV infection.

While HIV/AIDS counselling is similar to HIV/AIDS education, it goes beyond this by assisting people to deal with their emotional stress, by personalizing education messages and by enabling a confidential personal risk assessment to assist the client to make lifestyle changes needed to prevent transmission of HIV.

DISCUSSION POINTS

1. **Are there other goals of HIV/AIDS counselling not mentioned in Chapter 1?**

2. **What are possible problems and counselling implications for a person whose partner is HIV-positive?**

3. **In your own area, which people are most at risk of becoming infected with HIV?**

4. **How might counselling differ in the pre-test and post-test situations?**

Chapter 2

Psychosocial and cultural aspects of counselling

The psychosocial perspective

The psychosocial perspective is fundamental to HIV/AIDS counselling. This psychosocial, or holistic, perspective sees the individual 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.

A central goal of HIV/AIDS counselling, therefore, is to restore or maintain the client's relations 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 particular, physical contact with the infected person should be encouraged as an important way of overcoming isolation.

Culture and tradition

Encouraging and motivating people to make decisions about changing their behaviours and lifestyles are major counselling tasks. They will be more likely to do so if the counsellor appreciates the cultural importance of the behaviour to be changed.

"Culture" can be defined as the habits, expectations, behaviour, rituals, values and beliefs that human groups develop over time. Culture is a product of the interaction of people, ideas and the physical environment. Through culture and tradition, people learn acceptable behaviour, what is right and wrong. Culture determines or influences social status and the use of language.

Culture strongly influences people's feelings and beliefs about health and illness, about caring for the infirm, and about death and loss. Traditions, handed down from one generation to another, may be particularly important during times of stress, especially illness or death. For example, one culture may see illness as punishment, another as fate. What one culture considers a normal response to illness, another may find strange.

Culture and tradition therefore influence how people interpret, explain, and respond to HIV infection and AIDS. The appearance of an epidemic of a new and dangerous disease may prompt people to look for explanations of its origin. Sometimes they blame God or some other supernatural power. Sometimes patients blame themselves.

In some parts of the world, AIDS is considered a "homosexual disease", a disease brought by "foreigners" or in some places as a disease acquired from infected prostitutes.

Every culture has certain kinds of beliefs, moral principles and ideas, preferred above all others. These are called values and they translate into customs, practices, ceremonies and rites of passage. Some values are practically universal - preserving life, for example - but the values which guide and direct day-to-day behaviour are usually specific to the culture in which they evolved. Counsellors should examine their own beliefs, so as to be able to listen without prejudice and without censure to people from different backgrounds and cultures. (See "The Counsellor's Values", Chapter 4.)

Counsellors should be sensitive to the way in which culture influences people's response to HIV/AIDS. If it is not culturally acceptable to openly display emotion, for example, the counsellor might help clients to find relief by talking about their feelings in private. In places where it is easier to discuss certain topics with strangers than with family members, the counsellor may help to find or establish a group of similarly affected people and train them to listen to, and support one another emotionally.

Different cultures have different rites for terminal illnesses, death and bereavement. The counsellor should ensure that those concerned can observe their customary rites and get in touch with those who perform them. The counsellor should be acquainted with the use of ritual observances for spiritual comfort or protection, and should know who administers or performs the rites, or who can be approached concerning spiritual matters.

The counsellor should be able to discuss such matters easily and explain reassuringly and repeatedly why it is necessary to inquire about intimate behaviour and speak openly about sexuality. Because HIV infection is transmitted sexually, cultural and personal attitudes towards sex and sexuality are extremely important. The counsellor should realize, too, that some people may hesitate for cultural, religious or moral reasons to consider the use of condoms, or any form of contraception.

Cultural issues in counselling

The counsellor needs to be sensitive to cultural differences, or admit unfamiliarity with a client's culture if this is the case. Counsellors should explore with their clients prevailing beliefs about illness, HIV infection in particular, and counselling. This can be done by asking questions such as:

- What do people believe causes illness, and how do they explain illness and death?
- What do they 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 recognized as helpers and healers? What types of treatment do they provide?
- 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 intimate matters with people who are strangers to them, of the opposite sex, or from different backgrounds?
- How do people feel about discussing condom use and other safer sex methods with their sexual partners?

(Additional questions on social and cultural topics may be found in Appendix II.)

Cultural expectations about sex roles, sexuality, and childbearing should be discussed. In some cultures, for instance, the absence of penetrative sex is the same as not having sex at all. Suggestions for safer sexual practices may therefore not be well received in many cultural settings. In these cases, it should be reiterated that the only completely safe behaviour (other than abstinence) is a monogamous, long-lasting relationship in which neither partner is infected with HIV.

The counsellor should anticipate that some information may be met with embarrassment, laughter, or anger, depending on the cultural context. On religious grounds, for example, a person might become angry with a counsellor who mentions masturbation. As always, the counsellor should respect the clients' beliefs but give them information about options for changing their behaviour.

Psychological states

A diagnosis of HIV infection will create considerable psychological pressures. The psychological states that develop in most people with HIV infection revolve around **uncertainty** and **adjustment**.

HIV infection gives rise to **uncertainty** about all aspects of one's life, including the quality and length of life, the effect of treatment, and the response of society. These issues need to be discussed openly and frankly.

In response to uncertainty, the person with HIV must make a variety of **adjustments**. Even the apparent absence of a response may, in itself, be an adjustment through denial (see below).

There is no way of predicting the reaction to news of HIV infection. The following are some of the possible reactions:

Shock

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

- numbness, "stunned" silence, or disbelief;
- confusion, distractibility, or uncertainty about present and future circumstances;
- despair ("Oh my God, everything is ruined");
- emotional instability (moving quickly and unpredictably from tears to laughter and vice versa);
- withdrawal - distancing from present issues and circumstances; reluctance to become involved in conversation, activities or plans for treatment.

Denial

Some people may respond to news of their infection or disease by denying it ("This cannot be happening to me"). While initial denial can help to 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.

Anger

Some people become outwardly angry because they feel that they are the "unlucky ones" to have caught the infection and they may engage in destructive behaviour such as harming themselves or others. With progressing illness, the person may become unfit for work yet still remain well enough to be out and about. Boredom with a life that is increasingly restricted - in diet, activity, social contacts - is common, and often a source of anger. Anger can be expressed as irritability, sometimes triggered by trivial and unimportant events. Anger can also be directed inwards in the form of self-blame for acquiring HIV, or in the form of self-destructive (suicidal) behaviour (see below).

Suicidal thoughts or actions

People who learn that they are HIV-infected have a significantly increased risk of suicide. Suicide may be seen as a way of avoiding their own pain or of lessening that of relatives. 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 of HIV infection or disease).

Fear

People with HIV infection or disease have many fears. The fear of death, or of dying alone and in pain, is very common. Other common fears may include fear of desertion, rejection, leaving children/family uncared for, disability, loss of bodily or mental functioning, and loss of confidentiality or privacy. Fear may be based on the experiences of others. It may also be due to not having enough information about HIV/AIDS. Fear can often be reduced by discussing it openly.

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 from them first". Initially the counsellor should respect the felt need for isolation while continuing a supportive counselling relationship. If isolation continues for a long period, the counsellor will need to look for its causes, and encourage a change of attitude.

Loss

People with HIV/AIDS experience feelings of loss about their ambitions, their physical attractiveness and potency, sexual relationships, status in the community, financial 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. And many will have to face their own physical vulnerability or mortality.

Grief

People with HIV/AIDS often have deep feelings of grief over the losses they have experienced or anticipate. They may also sense the grief of their close family members or others who care for them and witness their declining health.

Guilt

When HIV infection is diagnosed, there is usually a feeling of guilt about the possibility of having infected others, or about the behaviour that may have resulted in the HIV infection (e.g. unsafe sexual experiences or injecting drug use). There is also guilt about the sadness, disruption and loss that the illness will cause loved ones and families, especially children. Any unresolved guilt from the past will intensify.

Depression

Depression may arise for a number of reasons, including the realization that a virus has taken over one's body, the absence of a cure and the resulting feeling of powerlessness. A person may become depressed by the 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.

Anxiety

Anxiety can quickly become a fixture in the life of the person with HIV, reflecting the chronic uncertainty associated with the infection. Some of these anxieties include the increased risk of infection with other diseases; a declining ability to function efficiently; and the loss of physical and financial independence.

Loss of self-esteem

Self-esteem is often threatened as soon as HIV is diagnosed. Rejection by neighbours, co-workers, acquaintances, and loved ones can cause a 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, physical wasting, and loss of physical strength or bodily control can compound this problem.

Hypochondria

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

Spiritual concerns

The fear of death, or other common reactions to incurable illness, may create or increase an individual's interest in spiritual matters. Expressions of sin, guilt, forgiveness, reconciliation, and acceptance may begin to appear as a result of a search for religious support.

Factors affecting the severity of the client's psychosocial state:

- the person's physical health at the time;
- how well prepared the person is for the news of HIV infection;
- how well supported the person is in the community and how readily he/she can call on the assistance of friends and family;
- the person's prior personality and psychological condition;
- the cultural and spiritual values attached to HIV/AIDS, to illness, and to death.

SUMMARY

The psychosocial perspective is particularly important in HIV/AIDS counselling since it views the individual in the context of his/her social environment.

Culture and tradition influence the way in which people respond to HIV/AIDS. Counsellors should respect these responses by exploring the underlying beliefs about illness and, in particular, HIV infection. The counsellor's efforts to motivate behavioural change should take belief systems into account.

Counsellors have their own values and cultural beliefs of which they should be aware. However, during counselling the values and culture of the clients should be respected without judgement. They should help clients and their families to discover culturally acceptable ways of expressing emotions such as anger, guilt, fear or sadness.

Because HIV infection is transmitted sexually, cultural attitudes towards sex and sexuality are extremely important in prevention; it may be difficult to change culturally sanctioned sexual behaviour.

A whole range of psychological states, revolving primarily around uncertainty and adjustment, can develop in people with HIV/AIDS. These must be dealt with in counselling.

DISCUSSION POINTS

1. **Why is it important for a counsellor to examine and understand his or her own values, preferences and prejudices?**

2. **Why is it necessary to be aware of cultural influences on counselling?**

3. **When a counsellor learns of a tradition or practice that he or she finds objectionable, what are the possible ways he/she could react?**

4. **What are some of the reactions to news of HIV infection that a counsellor can expect from a client who has become infected**

   a) from a spouse?
   b) from a blood transfusion?
   c) from an unknown source?

Chapter 3

Counselling processes

The counselling situation

In counselling, two people (a care-provider and client) meet to resolve a crisis, solve a problem, or make decisions involving highly personal and intimate matters and behaviour. A warm, open and welcoming manner on the part of the counsellor is essential. The client may know nothing about counselling or what it involves. Talking to a stranger about personal matters may be frightening, intimidating, or culturally prohibited.

However, a certain degree of emotional detachment in assessing the client's case is also important. The counsellor needs to find the correct balance between a warm and supportive manner and an objective and rational approach to the problem. This is important in promoting the well-being and problem-solving skills of the client.

The counsellor should begin by finding out what the client knows about counselling and expects of the counsellor. If necessary, the counsellor should explain the process briefly, illustrating it with examples, discuss the client's fears about it, and then listen to the client's own account of the problem. The account will be subjective and perhaps inaccurate but the client should be satisfied that the counsellor is giving full attention to the matter. This is the basis of trust.

It is important to understand that counselling is about helping people, and that, as all people are different, there can be no universal or predetermined method of counselling. However, the need for prevention and the commitment to providing support are present in all cultures and contexts, and some basic aspects of these functions underlie the most effective counselling programmes.

Types of counselling

There is no one correct method of counselling which is appropriate in every case. As indicated in Chapter 1, approaches to counselling are likely to vary from one country to another, as well as among different social groups. The choice of the counselling technique is influenced by many factors, such as the availability of local resources. Most importantly, the type of counselling used will be based on:

- the clients' needs and circumstances, including their psychological state;

- the types of problems;
- the stage of the problem when counselling begins.

Depending on the client's needs, he or she may have to be referred to a more experienced counsellor, psychotherapist or psychiatrist. Counsellors will have to be taught how to recognize the need for referral. At any time during the counselling relationship, the client may have to be referred to alternative or supplementary services, such as community-based or self-help groups providing ongoing emotional support (see "Counselling Resources", Chapter 4).

There are many types of counselling. Three are described in this Source Book:

- crisis counselling;
- problem-solving counselling; and
- decision-making counselling.

Crisis counselling

Crisis counselling is most often used because of the threat that HIV/AIDS poses to survival and the social stigma involved.

An emotional crisis exists when a person feels:

- intensely threatened;
- completely surprised and caught unawares by whatever is happening;
- emotionally disturbed as a result of loss of control; and/or
- emotionally paralysed because there does not seem to be any solution to the problem: all efforts to resolve the crisis seem hopeless, or the results appear to be as harmful as the threat itself.

Note: Any event that a person perceives and defines as a crisis is a crisis for that person.

The counsellor should "begin where the client is". He or she should be reassuring and supportive as the client discusses the "crisis". The counsellor should not play down its seriousness, by saying for example: "You are overreacting", even if he or she feels that no real crisis exists. Instead the counsellor listens carefully and comments on the strength of the feelings, the fear, or the client's efforts to deal with the problem.

For example, certain clients who fear that they may have put themselves at risk may become extremely anxious. They then pass into a state of crisis and can no longer function normally. Even if it is clear that the risk was negligible, the counsellor should respect their sense of being overwhelmed. However, the counsellor can use this opportunity to impress upon the client what they must do to prevent infection in the future. Such a client may for some time need considerable and repeated reassurance. What is important is that the counsellor should respect the client's own definition of crisis, and go on from there to provide support.

Crisis counselling focuses on the client's feelings and accepts the client's own definitions. With people who are afraid that they are infected, an important question to start with is: "What have you done that makes you so afraid?"

When a client is in crisis, the counsellor should remain calm and accept the fear as genuine. He recognizes the need for denial or anger. The counsellor should not panic, offer false assurance, give advice, or take offence.

A crisis is made up four elements:

- the blow
- the recoil
- withdrawal,
- acceptance.

These elements account for the seemingly irrational behaviour of the person in crisis.

The blow is the shock of fearing or realizing that something is wrong - a symptom appears, or there is an awareness of being at high risk, or a test result is confirmed as positive.

The recoil occurs as the person struggles emotionally to come to grips with the full implications of the crisis. For example, after the blow of a positive test result, the person may deny and recoil from this new reality and hence demand a new series of tests in a different clinic.

This is a natural but transitory reaction. Some people can quickly begin to come to terms with, and adapt themselves to, their predicament. Many withdraw, however, to be alone with their sorrow or anger, and to isolate themselves. Others suffer depression or acute anxiety.

In general, however, with their own psychological resources and with skilful counselling, people can come through the crisis without permanent loss of self-esteem, and with a restored sense of control. They have then reached the stage of acceptance.

In a crisis, the counsellor moves quickly to define the problem and restore a sense of control. This can be accomplished by the use of the following techniques:

- Guided (structured) questioning. (Example: "We both need to know what is going on, so I am going to ask you some very direct questions. Afterwards we can move on to anything else you need to talk about".)

- Acceptance. (Example: "You may feel angry at yourself, at me, and everyone else. I accept those feelings".)

- Emotional support. (Example: "You may feel very frightened and you may need some extra time to talk. I am here for you".)

In using these techniques, the counsellor should:

- Stay in the "here and now", i.e. focus on the client's expression of current feelings and anxieties, and affirm his feelings.

- Check whether the client shows decision-making ability, or gives an impression of feelings of helplessness, hopelessness, and loss of control.

- Clarify what the client regards as the crisis and agree on a course of action to resolve or ease the crisis.

- Start to work on one aspect of the crisis, preferably one that can be more easily dealt with, to foster confidence in dealing with future problems.

The counsellor may need to repeat some information if the client is in denial or is too distressed to understand what is being said. In crisis counselling, as in all cases of counselling, counsellors should be able to make decisions about when and where to refer clients (*see* Counselling resources, Chapter 4).

Problem-solving counselling

Crisis counselling and problem-solving counselling often take place at the same time. A client feels able to manage the crisis depending on the degree to which the problem becomes comprehensible. Crisis counselling focuses directly on the present; problem-solving counselling is concerned with planning together the prevention of transmission, methods of coping with the reactions to HIV/AIDS, and medical care.

Problem-solving counselling relies initially and primarily on emotional support and empathy. While the "problem" of personal HIV infection cannot be solved, its present consequences can be clearly defined. The person concerned must have factual information on which to base decisions. The counsellor, too, needs certain information about the client (e.g. the number of sexual partners).

The problem-solving approach is used to help clients:

- understand the nature of the illness;

- think through the impact of the disease on daily living;
- acquire or strengthen personal skills for dealing with the crisis; and
- change behaviour to protect themselves and others.

In problem-solving counselling, the counsellor:

- defines all aspects of the problem, including the duration and its effects, as the client sees it;
- encourages the open discussion of the client's feelings, and demonstrates support and reassurance that these feelings are normal;
- assesses the client's past and present problem-solving abilities;
- reduces the problem into a number of less complicated and easily solvable components and establishes a plan of action for each sub-problem; and
- discusses the personal and other resources available or needed.

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 a better understanding of the problem.

Decision-making counselling helps the client to focus on disturbing but necessary decisions. Decisions that may need to be taken will 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, such as inheritance?
- 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?

These are not pleasant questions, but their consideration and resolution help to restore a sense of control.

Crisis counselling, problem-solving counselling and decision-making counselling are interrelated. They can be selected according to the client's needs at any given time. Each will be used many times with the same person or family.

Features of counselling

Certain features are common to all types of counselling:

Time

Providing the client with adequate time is important from the start. The process of counselling cannot be rushed. As seen above, the psychological reactions are complex and cannot be dealt with quickly. Time is also necessary to develop a helping relationship. Some people may require many counselling sessions in order to acknowledge the need to change a particular behaviour, to learn protective methods and the necessary negotiating skills to use them.

Acceptance

People with HIV/AIDS should feel that they are fully accepted by the counsellor, irrespective of their socioeconomic, ethnic and religious background, their occupation or personal relationships. Counsellors should not be judgemental. (See "The Counsellor's Values", Chapter 4).

Accessibility

Clients who need counselling should feel that they can ask for a meeting or call on the counsellor at any time. This may require counsellors to be available on a regular basis. It may also mean having to call on new helpers who, with some basic training, can provide additional counselling support. The counselling settings should also be geographically easy to reach.

Consistency and accuracy

Any information provided through counselling (e.g. about HIV infection, risk of infection, and risk reduction) should be consistent both in content and over time. The counsellor, therefore, needs to have a clear understanding of the "facts" about HIV infection and disease. All counsellors should have access to updated information about HIV and its management. New information should be reviewed constantly (see Appendix X).

Confidentiality

Trust is one of the most important factors in the relationship between counsellor and client. It enhances that relationship and improves the chances that the individual (or group) will act decisively on the information provided. Given the possibility of discrimination, ostracism, and personal recrimination that an individual diagnosed with HIV/AIDS may face, it is all the more important that confidentiality be guaranteed. Confidentiality forbids any reference to, or discussion about, a client except within a professional relationship, and then only with the consent of the client.

The question of confidentiality is particularly important in group counselling. Clients should always be given the opportunity to give their full informed consent before participating in a group counselling session.

Activities during a counselling session

Counselling sessions usually last between 15 minutes to over 1 hour. A number of activities will be important in every counselling session:

- Clarifying and addressing problems: During a counselling session, the counsellor should use the skills of listening and questioning to grasp the client's most pressing problem. This problem should then be clearly stated to the client. The session then proceeds to address the problem. For example, in a particular counselling session the problem could be how to inform the spouse of the client's serostatus.

- Provision of information on alternative resources: Once the problem has been identified, the dialogue can then proceed to discussing alternative ways of addressing the problem. The counsellor's role is to provide information on alternative sources of help. Experienced counsellors should always be equipped with various options for solutions to commonly occurring problems. "Knowledge of options is as vital to the counsellor as knowledge of anatomy is to a surgeon" (see "Counselling resources", Chapter 4).

- Selection of realistic alternatives: Counselling should then help a client to select alternatives that are feasible and likely to provide the personal satisfaction and support needed in addressing a particular problem. This may involve introducing the person being counselled to groups of people who have themselves been through similar experiences, particularly if they are willing to provide support. Such groups might consist of peer-groups of young people, of HIV-infected mothers, clients of prostitutes, homosexuals or drug-injectors. The groups may consist either of HIV-infected individuals or their partners.

- Stimulation of motivation and decision-making: When people feel that they have personal control over their lives and their decisions, and when their life-skills, self-respect, and confidence are increased, their motivation to make changes will become greater. Therefore, during every session, it is important to give positive encouragement of steps taken, attempts made, and a sympathetic but realistic appraisal of why they are, or are not, as successful as expected. Maintaining status within the community is also likely to be a source of motivation. Being able to explain that the actions to be taken or already attempted will help loved ones, may be a critical source of motivation.

Stages in the counselling relationship

The relationship between a counsellor and a client may be limited to only a few sessions. However, sometimes the relationship lasts for years during which regular contact is maintained. The counselling relationship can be divided into three stages - a beginning, middle and end.

Beginning stage

The counsellor begins by finding out what the client knows about counselling and expects of the counsellor. If necessary, the counsellor should explain the process briefly, illustrating it with examples, and discussing the client's fears about it (see "The counselling situation", Chapter 3). The opportunity should also be taken at this stage to assure the client of confidentiality. At the beginning, the counsellor may encounter resistance from the client due to initial distrust.

One way to encourage trust is to allow clients to tell their stories in their own manner. The counsellor may find the stories disjointed or rambling but should let them continue, while noting what is highlighted, played down or ignored. Allowing the client to tell his or her story demonstrates the counsellor's respect for the client; permits the counsellor to observe the client's feelings; and indicates to the counsellor the client's ability to communicate ideas, facts and feelings.

After letting the client tell the story in his or her own way, the counsellor should take a case history. This will help the client to tell the story in a more orderly way and to begin developing a helping relationship. The history will include basic personal data, as well as information on a client's beliefs, knowledge and concern about HIV infection.

While taking this history, the counsellor should note how the client speaks (shy, hesitant, direct), relates to the counsellor (looking away, angry, engaged), and the ease or difficulty of communication. The counsellor should also note whether the focus of the client's history is on central issues and whether the client's account seems consistent.

With an anxious client, the counsellor may begin with straightforward factual questions or delay taking the history until a relationship of trust has been established. With clients who seem at ease and ready to talk, history-taking may begin by exploring their feelings about their problem. (See Appendix IV for a sample personal history form and questions for determining the client's behavioural and attitudinal history.)

With the information obtained in the beginning stage, the counsellor starts to work with the client to prepare a plan of action. The plan of action of counselling in relation to HIV infection and concern about it is necessarily governed by the chronic nature of the infection and the possibility that it will end in an early death. With this reservation, action plans must be set which are related to what the client is to accomplish and what is to be expected of support systems. The plans will depend on the nature of the problem.

Preparing an action plan includes:

- finding out how the client would like the problem to be solved;
- determining what the client thinks should be done to manage the problem;
- clarifying what the client expects from counselling;
- describing the help that the counsellor can offer, giving realistic hope for change or assistance, and discussing the reasons for any limits on help;
- establishing long-term and short-term plans; and
- stating the counsellor's commitment to working with the client.

Middle stage

When the client is sure that the counsellor can be trusted, and will provide information, guidance and support, counselling enters the middle stage. At this stage, the plan of action is put into practice. The most difficult and critical task is often to re-establish contact with the family or explain to them how infection occurred.

In the middle (or action) stage, the counsellor should:

- support the continuing expression and discussion of feelings;
- refer to available formal and informal resources;
- monitor progress and modify plans as necessary;
- promote the continuation of changes in behaviour; and
- help the person to move towards acceptance and control.

End stage

After the client has shown willingness to participate in formulating and carrying through plans, counselling enters the end stage. This is often very difficult for clients who have built a close relationship with their counsellor. To the client, the counsellor may seem to be the only one who really understands him and his situation. Despite the need to remain objective, the counsellor may also experience some feelings of attachment for the client. The thought of ending the counselling relationship may be painful for both of them.

For this reason, the ending should be carefully planned. The client has often suffered many losses and, although functioning adequately, may feel unable to carry on without the counsellor's help. The counsellor may increase the intervals 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 relationship only when it is certain that the client:

- can cope and adequately plan for day-to-day functioning; and
- has a support system (e.g. family, friends, other intimates, support groups).

Finally, in the end stage, the counsellor should:

- prepare the client for a changed counselling relationship;
- support the maintenance of behavioural changes;
- help to handle any continuing problems in the family or workplace associated with the client's condition;
- if AIDS has developed, review plans for the management of illness and care of survivors; and
- make sure that all needed and available resources have been identified and are being used.

SUMMARY

Of the three forms of HIV/AIDS counselling, crisis counselling is most often required because of the serious implications of the infection. In a crisis, the counsellor's aim is to define the problem quickly and help the client restore a sense of control. Problem-solving counselling enables the client to handle the day-to-day difficulties associated with HIV infection. Decision-making counselling helps the client to deal with the numerous disturbing and difficult decisions which must be made. All three types of counselling are interrelated.

Approaches to counselling are likely to vary, but certain essential features, including acceptance, accessibility and confidentiality, are common to all counselling situations.

Counselling has a beginning, a middle and an end, each with its own particular characteristics, and each calling for certain actions by the counsellor.

DISCUSSION POINTS

1. **What are the differences in approach between the three types of counselling?**

2. **What activities are typical of the beginning, middle and end stages of counselling?**

3. **How might confidentiality be secured in your future counselling sessions?**

Chapter 4

Counselling skills and resources

Forming a helping relationship

Counsellors often look for techniques to help them to deal effectively with their clients. While specific techniques may be useful, forming a helping relationship is more important. For this, the attitudes and qualities of the counsellor are critical.

Counselling skills can be learned and effectively used only by people who are genuinely concerned about others. Unless the counsellor can empathize with the client's feeling and situation, counselling will fail.

A helping relationship is in some ways like a friendship, but differs in having a specific purpose. There is a built-in power imbalance because the person in need has to ask for help, and the counsellor should be available to provide it. The counsellor makes use of this relationship to help the client to solve his or her own problems while, at the same time, informing the client about the various available options.

The helping relationship and the development of counselling skills also require the counsellor's commitment. Counselling in relation to HIV infection is especially intensive and difficult. On a regular basis the counsellor is forced to face his own mortality, to deal with loss, to offer support to people in extremely distressing circumstances and sometimes to accept behaviour of which he/she may disapprove. Without commitment, a counsellor will not be able to provide the necessary support.

The counsellor's values

In addition to technical knowledge and skills, the counsellor should have self-knowledge, self-discipline and self-restraint. Counsellors should be able to identify how their own culture and traditions may affect their ability to discuss certain topics or accept certain behaviours. Counsellors do not have to like all their clients, but should be keenly aware of how their own feelings, attitudes and prejudices can negatively affect the counselling relationship. If a serious conflict seems likely, the client should, if possible, be transferred to another counsellor.

In order to examine their own needs and motivations, counsellors might ask themselves the following questions:

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

To support their clients emotionally and help them to change their behaviour, counsellors should pay attention to certain important values and attitudes which keep counselling focused and directed (see "Counselling Skills", below). Counsellors should view clients as individuals with problems and respect them without judging or condemning their past behaviour.

Counselling and communication

Communication is the counsellor's principal tool. The counsellor enters the private world of a person by asking direct and extremely explicit questions about activities or behaviour. Many people find these issues embarrassing to talk about. Family-planning counsellors, for example, may find it easy to discuss contraceptives, but not sexual behaviour. Despite their sensitive nature, these topics must be discussed openly in order for clients to understand and accept their situation, to change their behaviour if necessary and to consider adopting protective and preventive behaviours, for themselves and for others.

The counsellor should use language that the client understands, so that communications are clear. Unlike casual conversation, the information that is discussed in counselling is:

- **specific**,
- **focused**, and
- serves a **purpose**.

Specific information is sought to enable the counsellor to assess risk or determine a course of action, and to focus on clients' emotional reactions and their need for health care and social support.

Counselling skills

Because counselling almost always involves communicating about sensitive issues, and differs from advising, counsellors should develop the skills of:

- ACTIVE LISTENING. The counsellor indicates by words, expression and gesture that he or she understands what the client is saying.
- ENCOURAGING. In certain cultures people are taught not to express 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.
- RECOGNIZING. The counsellor should be skilled in recognizing and distinguishing the various emotions the client is experiencing.
- ACKNOWLEDGING. The counsellor should acknowledge feelings such as anger, sadness, and fear in a direct, unemotional way: "Your feelings are very strong and I accept them".
- EFFECTIVE QUESTIONING. Counsellors use questions to help clients state their feelings and problems. These questions should be open-ended, aimed at leading into a discussion rather than a single "yes" or "no" answer. They should also enable the client to give a variety of answers rather than one answer. For example, "How will your partner react to this information?", rather than, "Will your partner be frightened by this information?"
- EMPATHIZING. Empathy is more than sympathy; it involves trying to place oneself in another's situation. Although counsellors should empathize, they should also control their own emotions. Counsellors should find the correct balance between detachment and closeness in order to promote the autonomy and problem-solving skills of the client.
- RESPECTING. Counsellors should respect clients' views and beliefs. They could show respect, for instance, by asking a client to explain unfamiliar aspects of culture or personal belief. For example, "I don't know about it. Tell me more..."
- CLARIFYING. The counsellor tries to clarify either what the client has said (for example, "Do you mean ...?"), or factual information (for example, "No, HIV infection is not transmitted by eating out of the same dishes").

- **PARAPHRASING**. Clients can tell when they are being understood when counsellors repeat what the client has said in different words. For example, "You seem to be saying that you are afraid your family is not going to take care of you". The client might then agree with the interpretation. If not, the counsellor can clarify the matter.

- **CONNECTING**. Many people cannot see the connection between their behaviour and the responses of others. The counsellor should show how these are related. For example, "Have you noticed that when you withdraw and do not speak to your family, they get very irritated with you?"

- **CHALLENGING**. The counsellor should confront the client with inconsistencies in the story or failure to perform agreed tasks. This should be done in such a way that the client sees it as a positive act, not an expression of anger or blame.

- **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 information.

- **EMPHASIZING**. Often people avoid focusing on the real problem. The counsellor should pinpoint the most critical issues. For example, "Of all the things you talked about today, it seems to me you are most concerned about ...."

- **MAKING ACTION PLANS**. Counsellors should help clients to work out what courses of action are open to them, make realistic plans, and act on them.

- **STRUCTURING**. Structuring determines which problems or concerns need immediate attention, and which can be postponed. It is an essential part of planning, and probably one of the most critical skills in counselling.

- **MOTIVATING**. Counsellors should try to motivate their clients by offering positive encouragement of new behaviours. If the counsellor explains that changed behaviours will help protect the client's loved ones, this may be a critical source of motivation. Motivation is derived from the probability of greater gain rather than pain.

- **SUMMARIZING**. This is very much like paraphrasing in that it helps to ensure that the counsellor and the client understand each other correctly. The counsellor should review the important points of the discussion and highlight any decisions made.

Some common counselling errors

The principles of counselling are easy to learn, but are difficult to apply. Because of this, counsellors can make mistakes. Some common counselling errors include:

- Controlling, rather than encouraging, the client's spontaneous expression of feelings and needs.
- Judging, as shown by statements that indicate that the client does not meet 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 motivations, fears and anxieties.
- Unwarranted reassuring – trying to induce undue optimism by making light of the client's own version of a problem.
- Not accepting the client's feelings – saying that they should be different.
- Advising, before the client has had enough information or time to arrive at a personal solution.
- Interrogating – using questions in an accusatory way. "Why" questions may sound accusatory.
- Encouraging dependence – increasing the client's need for the counsellor's continuing presence and guidance.
- Cajoling – persuading the client to accept new behaviour by flattery or deceit.

Non-verbal techniques

Throughout each session, the counsellor pays careful attention to both verbal and non-verbal messages. The following table contrasts positive and negative non-verbal counselling techniques:

EXAMPLES OF NON-VERBAL TECHNIQUES IN A SELECTED CULTURE

Positive	Negative
Uses a tone of voice similar to the client's	Unpleasant tone of voice
Looks client in the eye	Looks away frequently
Uses attentive facial expression, body movements and posture	Frowns, scowls or yawns
Suitable distance between counsellor and client*	Inappropriate distance
Does not speak too quickly or too slowly	Speaks too quickly or too slowly
Occasional gestures, such as nods, to acknowledge client**	Appears unreactive and fails to respond to the client's words or gestures
Uses humour, if appropriate, to reduce tension	Uses humour inappropriately or conversely, increases tension through a heavy, too serious tone

* In some cultures people stand very close to one another while talking, and look one another in the eyes. In others, people stand well apart, and turn slightly away from one another. A counsellor who uses the "close" style will fail with a person from a "distance" culture.

** People interpret silences and certain kinds of gesture differently. In some places, a shrug may express "I don't know"; in another place it may mean, "I don't care".

Talking about sensitive topics

It is helpful for the counsellor to obtain an understanding of how the client was infected with HIV/AIDS in order to help the client accept and cope with the situation and become aware of risks and how to avoid them in the future. Information about intimate behaviour will have to be gathered and interpeted. (In some contexts, certain behaviours may be socially disapproved or even illegal). There is no simple formula for getting people to talk about sensitive topics; effective discussion will depend in large part upon the ability of the counsellor to:

- gear his or her communication to the emotional and intellectual level of the client;
- make the client feel safe and secure by establishing a supportive relationship; and
- demonstrate his or her own ease in talking about topics usually avoided in ordinary social life or in medical consultations.

Whatever approach a counsellor uses, it will require skill, tact and sensitivity to the client. With some clients, the counselling relationship will evolve gradually. From the beginning, a rapport will need to be established. The counsellor will have to create an overall atmosphere that helps the client to develop a feeling of safety and trust, without which the counselling process will not be completely successful. The counsellor's style should therefore be reassuring, confident and open, but considerate of the client's feelings and fears.

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 practices and behaviour. The detail needed (e.g. number of partners, frequency of sharing needles) may embarrass the client, and even the counsellor, who should nevertheless find culturally acceptable ways of dealing with very sensitive topics (e.g. instructing clients in safer or protected sex).

As infection is commonly transmitted and acquired through sexual contact, it is particularly important for counsellors to be able to talk about sex and sexuality and enquire about unusual practices in such a way that clients will respond honestly, without taking offence or being defensive. In certain contexts, they may have to enquire about taboo or unusual practices. The counsellor should keep in mind that the risk of HIV infection may involve secret behaviour. Clients may hesitate to reveal any information for fear of condemnation by the counsellor. In some cases, the counsellor should understand and be able to use local or slang expressions.

Counsellors will need to assess their own readiness to discuss sensitive topics, or to what extent their inhibitions and attitudes will complicate the task. They should ask themselves:

- Which sexual practices will be most difficult for them to talk about given their own personal and cultural values?
- What everyday words will they use, or avoid, when explaining risk practices or behaviour, particularly to clients who differ racially, culturally, sexually or in terms of age from themselves?
- How will they explain the need to discuss intimate or taboo subjects?

Anyone seeking HIV counselling has many reasons to be hesitant about talking to a stranger: fear of what will be discovered, and of facing the infection itself; embarrassment about having to discuss very intimate matters; concern that confidentiality will not be respected; diffidence about talking to a person of the opposite sex, or of a different ethnic/linguistic group, or age.

Often, generalizing the situation to other people will allow a person to talk more freely at the beginning of the counselling sessions. A counsellor might say, for example, "Some people around here believe you can only get AIDS if you have sex with many partners (or from bar girls). Have you heard that?" By beginning with what "other people" think or do, the counsellor indicates that the client is not alone in whatever risk behaviour is being practised.

Questions are critical in counselling. Only through informed questioning can the counsellor elicit information about risk, check on understanding or misunderstanding of facts, and assist a client in deciding about courses of action. Questions might address, for example, relationships; difficult situations for the management of treatment; knowledge about HIV/AIDS infection; or the impact of any of the above on any other person. (See Appendix V, "Guidelines on talking about sensitive topics".)

Counselling resources

As HIV infection progresses into AIDS, different medical and psychosocial needs emerge. The counsellor cannot meet all of these needs. Rather, he or she should be fully aware of, and refer clients to the available formal and informal resources. Formal resources include medical care services (e.g. health centres, clinics, hospitals and hospices), income or food supplements, and counselling. Informal resources include families and friends, religious groups, civic clubs, and peer-support groups. If the need arises, the counsellor can also encourage the development of new social resources.

Information should be provided on the different types of facilities, self-help groups, community resources, and medical support that are available. Information on alternative behaviour, such as safer sex or avoidance of pregnancy, should be accompanied by information on where to obtain condoms and contraceptives.

If the formal resources are used, the counsellor can cooperate with the health care personnel to encourage his client to follow the prescribed course of treatment. This encouragement is especially crucial as the disease progresses, and in cases where previous medical care has been unsatisfactory or perceived as insensitive (e.g. disregard for his privacy). The counsellor can also perform practical services, such as obtaining medicines or arranging transport.

The growing prevalence of HIV infection and AIDS is straining the capacity of health services to provide the medical, counselling and educational services needed. Even with extra funding from government and other sources, few health services will be able to meet all the needs of HIV-infected people and their families. A key counselling task, therefore, is to mobilize or create additional resources (e.g. the training of voluntary health-care workers).

Reciprocal referrals by health centres, testing facilities, hospitals and other institutions to HIV/AIDS counsellors is equally important. The personnel of these organizations need to know, and inform people with HIV infection, where counselling is available.

They also need to be able to help the client find a counselling service that is physically and socially accessible and likely to be acceptable to the person concerned. Counsellors also need a referral system for difficult cases. Links should be established with psychologists and psychiatrists for this purpose.

Self-help groups

In some places, the counsellor can call on peer-support or self-help groups which are part of a growing network of nongovernmental AIDS service organizations. These can provide people concerned about HIV with personal care and peer-based psychosocial support which may not be available elsewhere. If no such groups exist, the counsellor can encourage clients to form them. Where this is not possible, the counsellor can put clients in touch with each other on an individual basis.

Matters that can be dealt with effectively through self-help groups include the following:

- Learning about living with HIV infection. Self-help groups are often in a good position to provide information and mutual support as the people involved may have already gone through the same process.
- 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. How to disclose a diagnosis of HIV/AIDS can be rehearsed, including what to say, to whom, when, and how.
- Peer-support groups can organize discussions and training to adopt or maintain new behaviours.

In support groups, as in group counselling, selection of group members should be sensitive to age, gender and sexuality differences among potential group members. For example, men who visit female sex workers may not find it easy to be in the same group as men who do not; teenagers may not feel they have much in common with older married women; men who have occasional sex with other men may not relate well to men who identify as gay; and street children may not be understood by moralistic adults.

SUMMARY

Counselling techniques are helpful, but most important is the ability to form a helping relationship. A helping relationship is in some ways like a friendship, but differs in having a purpose.

Counselling is both an art and a science, and requires not only a knowledge of HIV/AIDS, but also self-knowledge, self-discipline and self-restraint. The counsellor should achieve a balance between warmth and acceptance, on the one hand, and objectivity on the other.

Counselling involves both verbal and non-verbal communication. It differs from casual conversation in that the information exchanged is specific, focused, and serves a purpose. Counsellors should develop many skills, including listening, empathizing, challenging, motivating and the making of action plans.

To assess the client's risk behaviour, the counsellor should be able to obtain information on sensitive topics, such as sexual practices and drug injecting. This can be done only through informed questioning. Questions should also be used to ensure that all clients understand the basic information on HIV infection and its prevention.

DISCUSSION POINTS

1. What are some of the methods that you might use in your counselling role to form a "helping relationship?"

2. What is meant by "active listening"? What would be some signs of it in your own counselling setting?

3. If an HIV-positive client told you confidentially that he had recently had sexual intercourse with his under-age daughter,

   a) how would you feel as a counsellor?
   b) how would you proceed in the counselling situation?
   c) do you have any legal responsibility as a counsellor?

Chapter 5

Counselling for prevention and antibody testing

Antibody testing*

Voluntary testing is the anonymous or confidential testing initiated by either the client or his/her health care provider and performed with the client's informed consent. Such testing, when available, is a useful service for individuals who wish to know their HIV status.

In antenatal clinics, women who would like to know whether they are infected before making decisions about childbearing and/or breast-feeding, would generally participate in voluntary testing and counselling programmes. The only other role of HIV testing for patients is to assist in making a diagnosis of HIV infection when this is suggested by clinical signs and symptoms.

Antibody testing should only be offered when it can be accompanied by counselling before and after the test. This guarantees informed consent, confidentiality and clear information about the test and its implications, as well as emotional support.

Counsellors have to discuss with their clients, misconceptions and anxieties that they may have about HIV antibody testing. Counsellors should ensure that their clients understand what the test implies, and what a positive or negative result means. Many people believe that a positive antibody test means that they have AIDS, and this may cause great distress. The counsellor should stress that the available tests detect the presence of HIV antibodies in the blood and should add that current evidence suggests that all those infected will eventually develop AIDS.

People whose test is negative may feel relieved and believe that they can continue to live in the same way as before. Counselling should begin immediately. They should be told about the "window period", i.e. the period of three months or longer after the last exposure to possible infection during which time the test results may be negative, or equivocal. They should also be told what they should do to prevent acquiring or passing on the infection during this time. They should be urged to return for follow-up counselling, and for a repeat test.

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* For procedures and strategies regarding antibody testing see Recommendations for selection and use of HIV-antibody tests. *Weekly Epidemiological Record* 20, 1992, 67: 145-149.

People who are considering being tested must be given the information they need to be able to make a well-informed decision. The information must be up to date and cover the technical aspects of testing, as well as the medical and social implications. Confidentiality must be ensured throughout testing.

Testing of individuals or groups of individuals without their informed consent is coercive and has no advantages over testing with informed consent. Such testing, which is termed mandatory testing, has no place in HIV prevention and care programmes. However, all donated blood or body organs should be screened for HIV antibodies and potential donors should be informed that their blood will undergo HIV testing. Confidentiality of results of such testing should be strictly respected.

People sometimes donate blood primarily to know their HIV status. Blood transfusion services (BTS) should inform potential donors of the danger of donating blood when they feel they are or have been at risk. Sometimes people who have been at risk may go to donate blood at the time when they have not yet seroconverted even though they may be infected already (i.e. during the "window period"). In such instances, this blood will not be detected as HIV antibody positive. Because of this danger, it should be the practice of BTSs to provide pre-donation information and confidential pre-test counselling to donors in order to enable deferral or self-deferral of at-risk donors. Such donors should be referred to a separate facility where they can receive counselling and testing if necessary.*

The pre-test and post-test counselling process in relation to HIV infection is shown in the form of a flow chart (see Figure 1, page 44).

Pre-test counselling

Pre-test counselling is a dialogue between a client and a care provider aimed at discussing the HIV test and the possible implications of knowing one's HIV serostatus, which leads to an informed decision to take or not take the test. Such counselling should be centred on two main issues:

- the client's personal history and risk of current or past exposure to HIV; and
- the client's knowledge about HIV/AIDS and his or her ability to cope with crisis.

Tables 1 and 2 include information the counsellor will need to assess these issues.

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* *Weekly Epidemiological Record,* No. 44, 1993, pp. 321-323
Guidelines for blood donor counselling on human immunodeficiency virus (HIV), WHO/GPA/TCO/HCS/94.2.

Tables 1 and 2 include information the counsellor will need to assess these issues.

Table 1. ASSESSMENT OF RISK

(Assessment based on client's life)

- Current and past sexual behaviour and relationship(s) of self and partner (for example, one regular partner over many years, serial monogamy or multiple concurrent partners)
- Use of condoms, practice of safer sex; frequency of unprotected vaginal, oral or anal intercourse
- Sexual relations with multiple partners or known HIV infected partners
- High-risk behaviour, e.g. injecting drug use or commercial sex work (male or female)
- History of receiving a blood transfusion, organ transplant
- Exposure to possibly non-sterile invasive procedures, such as injections, tattooing and scarification

Table 2. ASSESSMENT OF KNOWLEDGE AND ABILITY TO COPE

- What does the client know about the test and its uses? Why is the test being requested?
- What particular behaviours or symptoms are of concern to the client?
- Has the client considered how he or she would react to the results of the test (positive or negative)?
- What are the client's beliefs and knowledge about HIV transmission and its relationship to risk behaviour?
- If the test result is positive, who could provide emotional support?

When making these assessments, it is important for the counsellor to remember that the client may not realize why the questions are being asked or may be reluctant to answer questions about private matters.

Once these assessments are made, the counsellor should:

- provide the needed factual information;
- review the test procedure;
- explain and obtain informed consent;[1]
- discuss potential implications (personal, medical, social, psychological, and legal) of a positive or negative test result; and
- establish a relationship of trust as a basis for post-test counselling.

During pre-test counselling, the client should be told that current testing procedures are not infallible. Both false-positive and false-negative results occasionally occur, although supplementary tests are very reliable. Information should also be given about the "window period" (see page 36).

As soon as a decision has been made to be tested, it is important to arrange for post-test counselling.

Post-test counselling

Post-test counselling is a dialogue between a client and a care provider aimed at discussing the HIV test result and providing appropriate information, support and referral, and at encouraging risk-reduction behaviours.

Post-test counselling is a process which starts with the results-giving session and may go on for several sessions thereafter to enable an HIV-positive client to come to terms with the diagnosis and to plan how to live with the knowledge. This is more so in the case of seropositive results but applies also to seronegative results. Counsellors should not aim to provide all information about HIV at the time of giving the results.

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[1] A decision to be tested should be based on informed consent. **Informed** in this context means that in discussion (pre-test counselling) the client has been made aware of all the ramifications of HIV testing, including the risks and benefits, as well as of alternatives to such testing, in language that he or she can understand. **Consent** means the giving of express agreement to HIV testing in a situation free of coercion, in which the client should feel equally free to grant or withhold consent.

The content of post-test counselling will depend on the test results (negative, positive or equivocal).

Counselling after a negative test result

It is very important to carefully discuss the meaning of a negative result. The news that the result was negative is likely to produce a feeling of relief or euphoria, but the following points must be emphasized:

- The test result may not be reliable because of the "window period", and the client may wish to consider returning for a repeat test after three to six months.
- Further exposure to HIV infection must be prevented. The importance of protected sex and other safer sex practices must be explained. Where relevant, the option of ceasing sexual relations with a partner who continues to have unprotected sex with other multiple partners and the avoidance of needle-sharing should be explained.
- Repeated explanations of positive health behaviours. The counsellor and the client should practise together ways of introducing and maintaining new behaviours with others (e.g. role-playing safer sex negotiating skills). If applicable, the counsellor might suggest meeting with client and regular partner/spouse together to discuss this.

Counselling after a positive test result

People diagnosed with HIV infection or disease should be told as soon as possible. The pre-test assessment can be used to determine the best way to tell the client about the test result. The first discussion should be held in private and be confidential. The client should be given time to absorb the news. After a period of preliminary adjustment, the client should be given a clear, factual explanation of what the result means. This is **not** a time to discuss how the disease will progress or to estimate the time left to live. It is a time to acknowledge the shock of the diagnosis and to provide support.

It is also a time for encouraging positive thinking. The client who has been diagnosed with HIV infection may have many disease-free years to live, and treatment for some opportunistic infections is effective and available. Treatment with anti-viral drugs should only be discussed in those settings where these are available and affordable. Important practical information for people with HIV/AIDS is presented in Appendix III.

At this point, the counselling relationship may enter a new phase. Crisis counselling is usually required because the news of HIV infection is received as a threat to life. How this news is accepted and incorporated often depends on a number of factors (see box on page 13).

Problem-solving counselling may also be necessary. The client should be told how to contact the counsellor during periods of severe stress. There should be some discussion of what may happen if employers or others learn that the person is HIV-infected. Routine follow-up visits should be arranged.

Counsellors should also give clear information about the long-term nature of HIV infection and when and how illnesses may occur. Clients should also be made aware that they will remain infectious throughout their lives and plans should be made as to how to protect their sexual partners.

The following points need to be repeatedly emphasized:

- HIV infection is not AIDS. Every infected person should be encouraged to live a normal social and economic life for as long as possible. Since normal living requires the support of others, those concerned may need counselling to anticipate and cope with new needs.

- The HIV-positive individual should take care of his or her general health. The counsellor should stress the importance of avoiding exposure to other illnesses or infections, as they will weaken the immune response, and may hasten the development of AIDS. The counsellor should explain how, through general home hygiene, people living with HIV/AIDS can avoid frequent common infections which may cause coughs, skin diseases and diarrhoea. Furthermore, the client should also be made aware of the importance of avoiding unprotected sex since this may result in the acquisition of sexually transmitted diseases which, in turn, may lead to the deterioration of the individual's health.

- HIV is transmitted primarily through unprotected sex. The only way to be sure that one is not going to infect someone else through sex is by abstaining or by always engaging in safer sex. If infected people wish to have sex, they must use a condom each time they have sex (see "The use of condoms" below and Appendix VII). They will always need to discuss the risks with the partner first. Spouses and partners may also need to be referred for counselling and/or testing.

- It is impossible to tell from a positive HIV test when the person was infected, or for how long. This point is important and needs to be discussed with clients so as to make sure that they understand that HIV infection may have occurred before an existing relationship began. It does not necessarily imply that the current partner has been unfaithful.

The advantages and disadvantages of informing key people in the client's life should be reviewed. The counsellor should stress the importance of informing sexual partners of a positive status.

There are practical reasons for telling the family and other close associates. Their own interests must be considered because they will be called upon to provide care and support to the infected person. Some individuals may feel intense guilt or shame for having contracted the infection (e.g. through a homosexual or extramarital affair). For this reason, disclosure can be difficult, and the counsellor may need to be present.

In helping the client to see the importance of this task, one of the most useful questions the counsellor can ask is: "What will happen to the people you love if you do *not* tell them now about what is happening to you?" The counsellor may help the client to consider how a spouse or partner has reacted in the past to some wrongdoing. Through role-playing, the counsellor can rehearse how the client will disclose his infection to others.

Counsellors should be aware of and share with the client some of the basic principles of partner notification, particularly that partners should be clear that they too have access to voluntary testing and counselling services. In the case of a client who has multiple sexual partners, the counsellor should discuss with the client who else may be at risk of infection (outside the primary relationship, if there is one) and options for appropriately notifying them.

In counselling infected persons, counsellors should provide information on the three ways of transmitting HIV/AIDS (see Appendix X).

In summary, after a positive test result, post-test counselling should:

- ensure that the person understands what a positive HIV test result means;
- discuss how the person feels about being infected;
- provide support to help the person deal with these feelings;
- discuss their plans for the immediate future;
- establish a relationship with the person as a basis for future counselling;
- schedule appointments for medical evaluation and follow-up counselling;
- schedule appointments for counselling of partners(s) if possible;
- refer the person to local community services, if available.

Counselling after an equivocal test result

A test result is considered equivocal if it is neither clearly positive nor clearly negative. In such circumstances, there are two main issues for the counsellor to consider:

1. The type of test used. Serum from persons being tested for the purpose of diagnosis should be retested if the results are equivocal. If the serum again produces equivocal results, testing with another ELISA (using a different technique) may be considered, especially for persons from low-prevalence (< 1%) populations. A second blood sample should be obtained after a minimum of 2 weeks following the first sample and both should be retested using the appropriate tests recommended by the country. If the second serum sample also produces an equivocal result, the person is considered to be HIV antibody negative. However, units of donated blood yielding equivocal test results must be discarded, as must units found positive.

2. Prevention and support following an equivocal result. The period of uncertainty following equivocal or indeterminate test results may be three months or longer after the last instance of potentially high-risk exposure or the previous test for HIV infection. It is important for counsellors to re-emphasize that the client will need to undertake the precautions recommended for HIV-positive persons until his or her status is proven otherwise.

The uncertainties associated with this period may lead to acute and severe psychosocial difficulties. The counsellor should assess and help the client manage such issues, making appropriate referrals if necessary.

It should be noted that, unless there are other signs of HIV/AIDS, it is at present impossible to tell by routine testing alone whether a newborn infant is infected. Infants born to infected mothers carry passively acquired maternal antibodies and will therefore be positive on an HIV test. Before 18 months of age, it is impossible to obtain unequivocal results confirming HIV infection, using readily available HIV testing methods.

The use of condoms

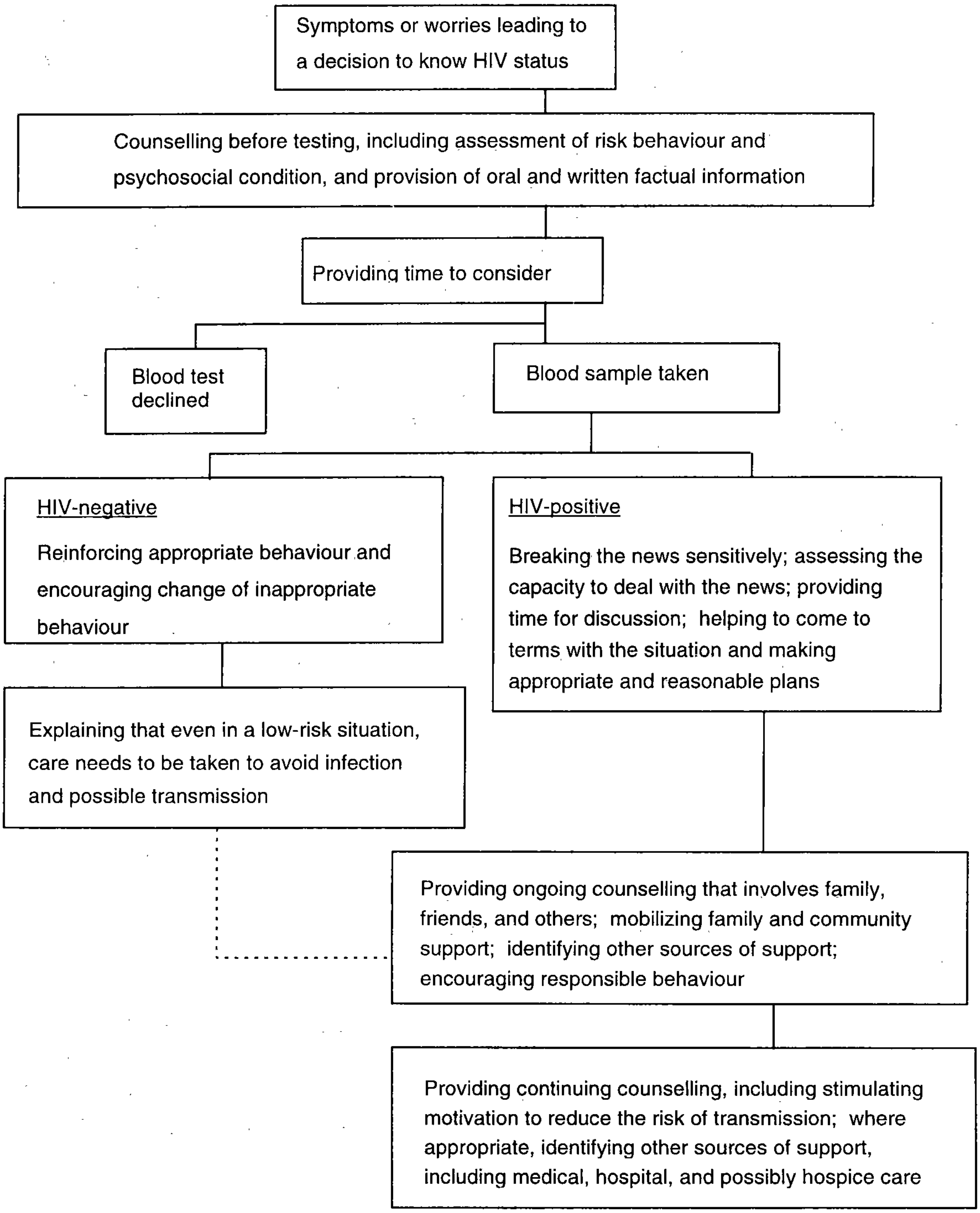
In post-test counselling, the counsellor should emphasize to clients of both sexes the importance of consistent use of condoms. Condom use may be resisted for a variety of reasons: reduced sensitivity/pleasure, implications of infidelity, or cost. Even if there is strong resistance, clients must be helped to assess the risks to themselves and others of not using condoms.

The counsellor should inform clients that condoms require practice to put them on properly and time to get used to them. Clients also need to be told that condoms are not foolproof against tearing or leakage. Appendix VII, "Instructions for condom users" can be given to literate clients to supplement the teaching provided by the counsellor.

As these instructions may prove difficult to follow, counsellors should, in addition, explain condom use in simple language. Culturally appropriate graphic material prepared by family planning associations can be used.

FIGURE 1

PRE-TEST AND POST-TEST COUNSELLING IN RELATION TO HIV INFECTION



SUMMARY

In all instances when HIV testing is carried out and the results can be linked to the name of the individual (linked HIV testing), pre-test and post-test counselling should be provided.

The purpose of pre-test counselling is to facilitate informed consent, prepare the client for the results and the implications thereof, assess the risk of the individual and make plans to reduce any risk behaviour.

Post-test counselling is provided in order to give the results, handle the immediate consequences and enable the client to cope with the psychological, medical and social aspects of knowing one's HIV status, as well as facilitating preventive behaviour. Thus post-test counselling starts from informing the client of the result and gradually progresses into ongoing counselling.

DISCUSSION POINTS

1. **What are the realities of pre-test and post-test counselling in your country or district, and how might these affect a counsellor's role in these situations?**

2. **Could group counselling be given in the pre-test situation? What methods could be used? What would be the limitations of pre-test group counselling?**

3. **What is the "window period" and what implications does it have for counselling associated with antibody testing?**

Chapter 6

Counselling for particular needs

Women

HIV can infect anyone – man, woman or child – of any age. However, worldwide, the number of infected women is growing faster than the number of infected men. In some places women die of AIDS at a younger age, and in equal, if not greater, numbers than men. These facts reflect women's relative vulnerability and their lack of access to means of prevention, health care and support.

The problems related to HIV/AIDS are not exclusive to women but may affect them more acutely because of economic and/or social inequality between men and women. In addition, they may have important implications for childbearing since HIV can be transmitted from an infected woman to her fetus during pregnancy, or to her infant either during birth or through breast-feeding.

Counselling infected women

Early counselling contacts, ideally in pre-testing, should especially focus on helping the woman feel safe in the counselling setting. Because intimate matters are discussed in HIV counselling, many women will prefer a female counsellor.

Counselling an infected woman should take into consideration how she has learned of her condition. A woman often discovers her infection by accident; usually after her husband/partner, or child is already symptomatic with an HIV-related disorder. The counsellor should recognize that the woman will be dealing with at least two crises, the crisis of her husband/partner's or child's illness, and her own crisis.

Disclosing her infection to her sexual partner and family can be very distressing, and she will often benefit from the support of an ongoing counselling relationship.

Women's concerns regarding HIV infection are not only medical but also social and cultural. Women are often wrongly accused of having brought HIV infection into their families, even if contradictory evidence exists. The counsellor should acknowledge the woman's fear that her family and friends will abandon her because of her actual or perceived past behaviour, and should provide emotional support.

A woman's infection may be the first indication of her or her partner's infidelity. The disclosure of this within the family unit may be very traumatic.

HIV-infected women often feel extremely lonely and isolated. Fear of social stigma may compel them to keep the condition secret. They may fear being abandoned, and deprived of the support of family, friends, and community organizations. Re-establishing connections with the family and other social groups, or finding substitute sources of support, is often a major task for the counsellor.

Many women have difficulty getting support from their families or partner's families. Counsellors should work with clients to determine if and how extended family members can be mobilized to help them. Educating families and communities is an effective way of helping individual clients.

Peer-groups of HIV-positive women may be an effective means of providing support for women who are estranged from family and friends. Even those whose social network is intact may derive benefit from meeting other women who are HIV-positive. A counsellor may be in a good position to arrange meetings for this purpose.

Common emotional reactions in an infected woman include:

- **anger** towards the person who may have infected her;

- **grief** at her loss of health and status, changed body image and sexuality, the possibility of having to give up having children and of dying and leaving her children alone; and

- **guilt** relating to how she may have been the cause of illness in her own family, particularly her children.

Infected women will be extremely concerned about the welfare of their children. In many communities it has been observed that a mother's main concern after testing positive is for her children. Women with children may tend to underestimate their own needs, or even fear coming to clinics because they are afraid that their children will be taken away.

All forms of counselling are used with infected women. Decision-making counselling (see Chapter 3) may need to be a major focus for infected women who have children or are pregnant. A mother may have to make arrangements for her children to be cared for after her own death or, if she is pregnant, decide whether to carry the fetus to term. Counselling may have to deal with cultural and religious beliefs, medical realities and moral convictions about abortion.

Sexual behaviour and protection/contraception

Most commonly, women are infected as a result of their partners' behaviour. However, women are frequently seen as the source of infection as they have been throughout history in the transmission of other STD. Prostitutes have been particularly singled out for blame rather than protection, and the clients' responsibility has rarely been acknowledged. This focus has the detrimental effect of implying that women are responsible for the spread of HIV.

Prostitutes are clearly a very vulnerable group as are many women especially in developing countries who have to exchange sex for material favours on a regular or irregular basis.

Some women receiving HIV/AIDS counselling will have been involved in prostitution or the exchange of sex for material favours. The counsellor should remain non-judgemental (see "The Counsellor's Values", Chapter 4)

As the most common means of transmitting HIV to women is through sexual intercourse, the counsellor needs to be comfortable talking frankly about contraception/protection and HIV infection. He, or preferably she (see above), should not hesitate or be embarrassed to encourage the woman to talk about sexual practices and alternatives. Although women may find it embarrassing, it is the counsellor's job to put them at ease.

It is extremely difficult for women in many places to gain compliance with safe sex from their male partners. Many women are uncomfortable or afraid of asking sexual partners to use condoms. They risk conflict and sometimes abandonment or violence. However, the counsellor should encourage the woman to find ways of negotiating their use without conflict. Women as well as men should know how to use condoms correctly. (Please refer to the information in Appendix VII, "Instructions for condom users".)

Whether or not other contraceptive methods (such as intrauterine devices [IUDs], hormonal contraceptives, diaphragms) are employed, condoms should always be used whenever there is a risk of sexual transmission of HIV infection, e.g. in sexual relations outside a stable, mutually faithful, monogamous relationship.

Transmission of HIV is facilitated by both ulcerative and non-ulcerative STDs and possibly IUDs. The treatment of STD is an essential part of HIV prevention. However, STDs in women are often neglected partly because many of them are asymptomatic in women and partly because women lack the time and money to get treated.

Women of childbearing age who are HIV-infected should receive post-test counselling to permit them to make an informed decision about avoiding pregnancy. In view of the risk of mother-to-infant transmission, the counsellor should stress, but not impose, the option of contraception. However, the importance placed upon childbearing may be so great within her culture that the woman will risk giving birth to an HIV-infected infant.

Many women who learn of their infection during pregnancy, choose to carry their pregnancies to term.

Because the risk of transmission from mother to infant is estimated to be approximately 1 in 3, the pregnant woman should be prepared for the possibility that the child will be born with HIV infection. In the case of an infected pregnant woman, a discussion of pregnancy termination will depend on personal, religious and cultural factors, as well as the national law on abortion, the stage of gestation, and the local availability of safe facilities.

Pregnancy

The prognosis for the pregnant woman with HIV infection, in terms of disease progression, is uncertain. However, it is thought that early in HIV infection (when women are asymptomatic), pregnancy has little, if any, effect on the progression of HIV infection. Similarly HIV infection probably has little, if any, effect on the complications and outcomes of pregnancy. This may not be the case later in HIV infection, especially when the woman has severe AIDS. Pregnancies in women with AIDS are frequently complicated, especially by early (premature) labour, as might be expected in any seriously ill or debilitated woman.

Infected pregnant women may require more frequent medical and psychosocial support services. This support may be more effective if the partner is involved. When appropriate and with the woman's consent, decisions about terminating a pregnancy or preparing for a potentially infected infant should involve both partners.

Given that many infected women will choose to bear children, a counsellor should help the woman develop a plan for how she will care for her child, how she will cope with the possible illness of the child, how her family and community will help her, and how she expects to support and care for her child if she becomes sick.

Breast-feeding

HIV infection can be passed from an infected mother to her baby through breast-feeding. The risk of transmission through breast-feeding seems to be higher in women who are recently infected and women with AIDS than in women who have been infected for more than a few months and who do not have any symptoms. This is because the level of virus is higher in women with new infections and with AIDS. However, breast milk is almost always the best food for babies. It is the baby's best protection against diarrhoea and many other diseases. Women who are HIV-positive should be helped to assess the potential dangers of not breast-feeding against the risk of the child getting infected by HIV through breast-feeding. Breast-milk substitutes lack anti-infective properties (which breast milk has), so artificially-fed infants are more likely to suffer from a range of infections and other conditions. In situations where hygiene is poor and there is a lack of clean water and fuel, the risks are greatly increased because formula milk may be contaminated with germs, causing diarrhoea.

The counsellor will need to assist a known HIV-infected woman to assess her medical condition, her living conditions, her child-care arrangements if she will not be providing full-time care for her baby, and the support she has from the family and friends. The counsellor and client will need to discuss together whether she can afford a nutritionally adequate breast-milk substitute, and whether there is a supply of clean water for it to prepared safely. Because decisions regarding infant feeding will also affect the entire family, joint counselling with the mother and appropriate family members will be needed in addition to individual counselling for the mother. Ultimately, it is the mother and family who decide how a baby will be fed. It is important that a mother be provided with accurate information to be used in making her decision, that she be allowed time to consider carefully her decision, and that she be supported in her decision in keeping with available resources.

SUMMARY

Women with HIV infection are particularly susceptible to social isolation within their families and communities. Emotional support and assistance in re-establishing social networks will be needed.

Because the most common means of HIV transmission for women is through sexual intercourse, they must consider how the risk behaviour of their sexual partners, as well as their own, could affect their health. The use of condoms and the treatment of STDs are crucial preventive measures.

Decision-making about pregnancy will be an important part of counselling an HIV-infected woman.

DISCUSSION POINTS

1. **What information would women typically need about prevention that is different from that routinely given to men?**
2. **What are some of the issues related to becoming pregnant which a counsellor would discuss with a woman who believes that she has been exposed to HIV infection?**
3. **What are some approaches that may be taken to negotiate safe sex or no sex?**

Families

The family is a group of people linked by feelings of trust, mutual support and common destiny. In most societies, families are the main source of care and support for those with HIV/AIDS. The type of care required changes, depending on the stage of infection. As the type of care becomes more demanding, so the burden on the family increases. The time and energy required and the emotional involvement will become greater and draw the family away from other activities and responsibilities.

Family members may experience the same fears regarding social stigma as the infected person: they fear that others will regard them as sharing the "contamination". Because of imagined or actual social pressure, the family may deny, or avoid the subject of the infection or illness. The "conspiracy of silence" imposes a strain on the household. Those who care for the patient may conceal their emotions, and thus give an impression of indifference to the patient. These and other concerns should be addressed in counselling, both at the individual and group levels.

In some places, people with HIV/AIDS leave, or are abandoned by their natural families, and live with friends in "families of affiliation" who provide the care and emotional support traditionally expected of the family. The counsellor should be accepting of all types of families and strengthen the support that can be provided by them.

Emotional impact of HIV/AIDS on the family

It will be important for the counsellor to realize that some families will not only be learning that a family member has HIV infection, but possibly also, for the first time, that he or she has been involved in some form of sexual or drug-related behaviour unknown to them. Infected individuals may be rejected by some family members for such transgressions, causing division within the family.

As the disease progresses, the person who is ill may have to give up work and/or the partner may have to give up work in order to look after him/her. This may result in a decline in family income, and lead to feelings of resentment towards the "cause" – the patient. The patient's reactions to the disease (e.g. depression, mood swings, anxiety, hostility towards care-givers) may overstrain the family's tolerance (see "Psychological states", Chapter 2).

If the family members can pass through this crisis successfully, they are likely to continue to support one another. Families which do not resolve the crisis are more likely to ignore or reject the infected member. Moreover, the unresolved issues will continue to harm family relationships long after the death of the infected person. When the person dies, families will also have to deal with loss.

A critical task of counselling in the context of HIV is to help the family understand the strength of the emotions and the reasons for the irrational outbursts that may accompany infection and illness. The family will need continuous support, so as to be able to withstand them.

Disruption of couples and families of affiliation

A revelation of HIV/AIDS can create severe marital stress. Common reactions are a sense of betrayal and/or resentment at the infected partner's irresponsibility in jeopardizing their health and life. In many cases, the revelation of one partner's HIV-positivity will lead immediately to the revelation of the other's. Some couples may become estranged from one another and separate immediately. Others are able to stay with and care for the infected person or for each other.

Problems of intimacy and trust arise. Couples will have to deal with a number of issues, such as whether sexual relations will continue and, if so, whether they will use condoms. In cultures where women are regarded as subordinate to their husbands, the possibility of forced sexual relations and thus possible further transmission should be considered. Tension will be increased as a result of concerns about their finances and the future of their children.

Affiliated families (e.g. male homosexual couples with a circle of friends or "family" members) react to the discovery of HIV infection in much the same way as married couples. If the infected person is abandoned by his affiliated family, the counselling task is to either reconnect him with his family of origin or help him find other sources of support.

SUMMARY

Regardless of a family's form or structure, the discovery that a member has HIV/AIDS leads to high levels of stress and disruption in all areas of family life. Some families cut themselves off completely from the infected person, while others provide care. Most families fall somewhere in the middle. All are deeply affected - personally, emotionally and socially - by their decision.

How families cope with this stress will depend on the characteristics of the individual members, the family as a whole and, in some instances, those of the counsellor. Acceptance and growth, however, are not uncommon.

DISCUSSION POINTS

1. **How might counselling a traditional family differ from counselling an affiliated family?**

2. **What are some of the issues that a family will have to deal with when it is revealed that one of its female members is both a prostitute and HIV-infected?**

3. **What would be your response to an angry father who says that his son's AIDS is "divine retribution" for his lifestyle?**

Children

Increasing numbers of infants are being born with HIV infection; millions more are being orphaned by the death of one or both parents; the number of child-headed households in Africa is rising dramatically; and many orphans drop out of school and join the ranks of street children.* In each of these situations, children, their parents, the whole family and sometimes relatives and friends will have counselling needs related to their particular problems and circumstances.

The children most affected by AIDS are those with the disease. When HIV infection is present at birth, parents must begin to anticipate the possible loss of the child. Grief is an expected and necessary reaction (see "Psychological states", Chapter 2).

The stability of family life will have an impact on the care of an infected child. Parents will have to deal with their own emotional reactions (e.g. grief, self-blame and guilt) to prevent the disruption of family life. The counsellor should seek to assist the family in finding ways to ensure that the child develops physically and socially to the fullest extent possible. If parents cannot provide the care required, the counsellor may need to assist in finding substitute care. As most families will care for the child at home, they may need special services, including subsidies to cover the costs of supplies, transport and other essentials.

There is virtually no risk of HIV being transmitted in the home to other family members. Although the risk is low, care should, nevertheless, be taken to avoid contact with the blood of the infected infant or child. The counsellor should provide families with practical information about hygiene. Care-givers should protect and cover breaks in the skin and abrasions. Siblings and other children should be taught to avoid contact with the blood of the infected infant. Other children must be told not to handle blood or open wounds with their bare hands. However, they must be assured that they can handle and play with the infected child without being afraid or anxious. (See Appendix VIII for information on infection-control procedures.)

Infected infants and children should receive adequate affection and be treated as normally as possible. Just as with the adult, emotional support and adequate nutrition must be assured. This may require the counselling of parents and siblings. If possible, the counsellor should put the parents in touch with a local self-help parents group.

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* *Action for children affected by AIDS: programme profiles and lessons learned.* WHO, Geneva/UNICEF, New York, 1994 (WHO/GPA/TCO/HCS/94.7).

Counselling infected children

Certain counselling approaches and techniques can be adapted for use with HIV-infected children. The counsellor should stress to parents that it is their responsibility to tell their children about their condition and why they are coming for counselling. The counsellor can help the parents or guardians with their explanations.

Counselling sessions should generally not be long. As a rule, the child should be included in interviews with the parents and, where appropriate, with grandparents and siblings. The counsellor can then observe the reactions of both child and family. Older children can be seen either alone or with the family, as the child prefers. If the child is seriously ill or dying, the parents may need to see the counsellor alone.

Role-playing is one counselling technique that can be used effectively with children. For example, in helping them to deal with discrimination at school, a parent can play the role of a teacher who wants to know more about the child's illness. The counsellor can ask questions, using the child's vocabulary, in order to check what the child already knows before giving additional information.

The school setting

As HIV is not transmitted by normal social contact, infected children do not pose a risk to others in their school and other children should not be informed about their status. However, if children do know that a child at their school is HIV-infected they should receive age-appropriate information about the infection. Where a school child has HIV, it may be to the advantage of the child if the school health service, as well as the child's teacher, are informed confidentially about the HIV infection after explicit consent of the parents. In this case, the counsellor is free to discuss possible problems, such as social stigma, with them. However, if they do not know about the HIV infection, the counsellor should not divulge that information without the consent of the child's parents or guardians.

Children often respond to the reactions of the adults around them, so that it will be important for the counsellor to ensure that the children's parents and teachers, when appropriate, are well informed. Even then, school staff may not believe reassurances about the low risk of transmission and may even try to keep children who are known or suspected to be HIV-infected out of school. The problems arising in the school setting should be dealt with as quickly as possible to ensure that they do not reach this point.

Every school should have written instructions for school staff on routine procedures for handling blood or other body fluids of all children regardless of whether they are known to be infected or not. (See Appendix VIII for procedures.)

SUMMARY

In the case of a child infected with HIV/AIDS, the counsellor may need to provide assistance to the entire family. Parents and siblings will need help to resolve their grief and to learn how to care for the infected child.

If the parents are unable to provide adequate care, the counsellor may need to identify substitute care.

Counsellors should be aware that infected children and their families may experience discrimination. They should educate teachers and other parents that the risk of transmission in the school setting is low.

DISCUSSION POINTS

1. **What might be some of the differences associated with counselling an HIV-positive child who has both parents, one who has one parent, and one who has guardians?**

2. **What could you do as a counsellor when an infected child is discriminated against at school?**

3. **How would you counsel a 10-year-old HIV-positive child who wishes to play contact sports?**

4. **What are some special considerations for counselling a 10-year-old HIV-negative child whose parents have died from AIDS-related diseases?**

Appendix I

Living positively with AIDS

If you have AIDS, you should try to keep your body strong. This means you should:

- Eat a diet which includes foods rich in proteins, vitamins, and carbohydrates. Your body needs food to build it up, to give it energy and protect it from infection;
- Stay as active as possible in order to keep fit, and get regular sleep. Exercise helps prevent depression and anxiety and can add to a general feeling of well-being and contribute to general health and stamina;
- Continue to work, if possible;
- Occupy yourself with meaningful or at least distracting activities;
- Give both physical and emotional affection;
- Socialize with friends and family;
- Talk to someone about the diagnosis and illness;
- Use a condom during sexual intercourse; and
- Seek medical attention for health problems and follow the advice for care, including advice from counselling and social services. This includes preventive services, such as immunization for children and infants with HIV/AIDS. Reduce or avoid stress by identifying potential and actual stress factors.

And you should be cautious about:

- Alcohol and cigarettes. It is harmful for anyone to smoke. Smoking damages the lungs and many other parts of the body and makes it easier for infection to enter. Drinking too much alcohol hurts the body, especially the liver, and can also make you forgetful. You may forget safer sex and get exposed to other sexually transmitted diseases.
- Exposure to other infections such as other sexually transmitted diseases and tuberculosis.

- Pregnancy. You should seek advice from your health care worker before deciding to become pregnant, or to make your partner pregnant. A baby needs healthy parents to care for it! Your baby may be born with HIV.

- Use of unprescribed drugs. Some drugs are addictive, others have serious side effects. Only take drugs which have been prescribed by your health worker.

- Isolation. Being HIV-infected should not exclude you from socializing with other people. Try not to isolate yourself. The more friends you have and keep the more likely you are to seek and receive support.

Appendix II

Obtaining sociocultural information about clients

Sources of sociocultural information include clients, clients' families, community leaders and other health and social care givers, including religious leaders and traditional healers. This information can be collected by holding focus group discussions attended by 6 to 12 individuals. Where it is not possible to conduct formal focus group discussions, the information may be collected through individual discussions. Learning about the community's culture and beliefs is a necessary prerequisite for a good counsellor. This knowledge should not always be assumed even if the counsellor is from the same community and culture as the clients. Those providing HIV counselling need to take time to understand the client's living environment and social surroundings. Sociocultural information can be obtained by asking the following questions:

- What are the main ethical and religious principles in the society related to kinship, marriage, celibacy, widowhood and divorce? How do these apply to sexual unions, either before, during and after, or between marriages, in relation to the sexual life cycles of individuals?

- What are the main forms of penetrative and non-penetrative sex practised, among which groups, and to what extent are they related to each other? Are there any sexual practices which may be especially conducive to the spread of HIV infection (e.g. unprotected vaginal or anal intercourse with multiple partners)?

- What information is available on topics such as coital frequency and periods of abstinence, e.g. during menstruation, pregnancy and breast-feeding?

- What forms of contraception and/or protection from HIV/STD are used in different types of sexual relationship and through the sexual life cycle, with particular reference to condoms?

- How are migration and other forms of travel associated with patterns of sexual behaviour?

- To what extent do people engage in sex in exchange for money or other resources and what relationships of this type exist? What are the characteristics of people who engage in these relationships? To what degree are they socially acceptable?

- Do homosexual and bisexual relations, injecting drug use and commercial sex occur? If so, among which groups and to what extent do the individuals concerned interact with others in the population?

- To what extent are young people, especially girls, vulnerable to HIV/STD infection. How, if ever, do young people access information on sexuality and safer sex? What is the availability of condoms, contraceptives and STD services for young people?

- In what ways are sexual matters discussed between spouses/partners, within families, between friends, in schools and in the media?

- To what extent are people aware of AIDS? Does it have a local name? Is there any understanding of the difference between HIV infection and clinically expressed AIDS?

- To what causes do people attribute AIDS: a biological cause (a virus) or a metaphysical cause (punishment from God, witchcraft, etc.)? To what extent is ill-health in general seen as accidental, due to environmental factors, or as a consequence of moral transgressions? Are there any locally perceived risk factors, such as migration to a large town or, for example, "walking in the bush at night?" Do people understand the concept of contagion through contact with another person? Are drugs injected and are injectors seen as being at risk? Is there seen to be any association with particular occupations, such as midwifery, or with animals?

- How is AIDS recognized? What are perceived to be the symptoms of AIDS and how are they distinguished from those of other diseases? What is believed to be the likely course and outcome of the disease? Are there believed to be any social consequences and behavioural manifestations of the illness?

- Do people have any ideas on prevention or ways of protecting themselves and their families? (Public health measures such as those mentioned in health education campaigns should be mentioned only after local ideas have been explored.) To what extent do people see themselves and their families to be at risk and what steps are they taking to reduce that risk.

- What treatment is given locally to AIDS patients? To what extent are health service facilities used? Is there a role for centres such as hospices? Who is responsible for the care of AIDS patients in the home and how does this affect domestic roles and economic production? To what extent is the local community involved, including religious leaders and traditional healers?

Appendix III

Practical information about HIV/AIDS for clients

- HIV infection is not the same as AIDS. People with AIDS have HIV infection, but only some of those with HIV have AIDS. However, current evidence suggests that all those infected will eventually develop AIDS.

- Unprotected vaginal intercourse is the major route of transmission of HIV. Infection can be prevented if condoms are used correctly. Non-barrier contraceptives have no protective effect against HIV transmission. It is not clear whether oral and injectable contraceptives affect the risk of HIV transmission.

- Sexually transmitted diseases (both ulcerative and non-ulcerative) facilitate the transmission of HIV infection.

- Certain health conditions, may accelerate the progression of HIV infection to AIDS.

- The risk of transmission of HIV infection from a woman to her child during pregnancy, delivery or through breast-feeding is approximately 1 in 3. If a woman has AIDS she is more likely to have problems with the pregnancy.

- Persons with HIV infection should never donate body organs, or body fluids, such as blood, semen, and breast milk.

- People with HIV infection should not share syringes, needles, or other skin-piercing instruments. People with HIV should avoid being tattooed or having any other invasive procedure unless sterilization of the instruments can be ensured before and after the procedure.

- Drug injectors who are unable to stop using drugs should obtain sterile needles and syringes (if this is possible) or disinfect, with bleach, equipment used for injection. Some countries or cities have needle and syringe exchange programmes.

- People with HIV infection should not share toothbrushes, blade razors or other items that could become contaminated with blood (even though the risk of HIV transmission in this way is extremely low). The following activities do not involve a risk of HIV transmission: casual social contact, hugging, sharing crockery and cutlery, being in the same room, sharing swimming pools and lavatories.

Appendix IV

Taking the client's history

Personal History Form

Name ____

Address ______________________________________

____

Date of birth ______________ Sex __________________

Ethnic group ______________ Religion ________________

Marital status or involvement in an intimate relationship

____

Number of children and where they live

____

Educational level/ability to read and write

____

Occupation and source of income

____

Recent health history

____

State of health of spouse (s), partner (s), other intimate friends, children, family

____

Name of personal or family doctor or medical service

____

Name of person to contact if necessary

____

Questions to determine the client's attitudinal and behavioural history:

- What does the client think is wrong?
- Have any signs or symptoms of illness appeared?
- If they have appeared, how long have they been evident?
- What has the client done so far about seeking help or treatment?
- What does the client believe caused the illness?
- What kinds of risk behaviour, if any, are involved?
- If there has been risk behaviour, has it been changed?
- What reactions from others does the client expect? Does he/she perceive that he has a support network?
- Is the client hopeful of solving his/her problems, either alone or with the help of the counsellor or others?

Appendix V

Guidelines on talking about sensitive topics

The following guidelines on talking about sensitive topics will be useful to counsellors:

- Ask direct questions so as to be clear about what is worrying the client, and what he or she wants and expects from the counsellor.

Example: What do you want from me (this clinic, hospital, etc.) right now? What made you decide to come here now?

- Establish the reasons for the client's concern or belief that he or she is infected or at risk of infection.

Example: You tell me that you are afraid you have AIDS. Tell me what you know about the ways in which people become infected. In which of these ways are you most at risk?

- Anticipate a certain degree of embarrassment at discussing sex; point out that you realize that people do not usually discuss it in such depth.

Example: We do not usually talk very openly about sex in our country. But, now, since you believe you may have been at risk of infection, you and I must determine the degree of risk. To do that, I have to ask some very specific questions. Most people feel a bit embarrassed by these questions, and you may too. For example, I need to know whether you have had sex with casual partners over the past six months.

- Explain clearly why you must enquire into sexual practices and other practices such as drug injecting — that it is in order to determine precisely what the client needs to do to prevent becoming infected or passing the infection to others.

Example: HIV is transmitted in a number of quite specific ways. The most common way is through unprotected vaginal intercourse. It is also transmitted through heterosexual or homosexual anal intercourse. If either partner has an STD, the chances of HIV transmission are higher.

- Explain why you are asking questions about all forms of transmission.

Example: Sometimes people are offended when I ask about practices that seem strange or even repulsive because they are not common in this area. But, people travel, and sometimes experiment, so we must make sure that all the possible risks are covered.

In interviewing, the counsellor should use the formal expression first (e.g. vaginal intercourse). If it is not understood, the slang expression should be used and the client asked which one is preferred. The client must not feel that the counsellor is making any moral judgement on any sexual behaviour or other risk behaviour.

The counsellor should check frequently to make sure that the client understands what is being said — for instance, by asking the client to repeat in his or her own words what the counsellor has been saying.

The counsellor should also ensure by asking the questions given below that everyone being counselled for the prevention of HIV infection receives and understands the following messages:

- There is no cure for HIV infection. Prevention is the only defence at the present time.

Questions: How do you think that HIV infection is spread? If you want to stay free of infection, what changes will you have to make? Changes of this kind are difficult for most people — what can we do to help you make them? What will you tell others (spouse, partner) about why you are changing your sexual behaviour?

- Change of behaviour is difficult. One needs to identify one's personal risk and devise ways to reduce it.

Questions: What do you think people find most difficult when they give up (whatever the risk behaviour is)? What do you think might be hardest for you? When you say you do some risky things, what do you mean?

- HIV transmission can be prevented only through abstinence, or sex without exposure to blood, semen or vaginal/cervical fluids. To lessen the risk of sexual transmission, men should use a condom each time and from start to finish. Women should ensure that their partner uses one and refuse sex if he will not. The more sexual partners, the greater the risk of exposure. Drug injectors should not share syringes or other drug-related instruments that pierce the skin with anyone else.

Questions: Do you think it is possible for you and your spouse/partner to abstain from sex? Have you tried condoms? When you and your spouse/partner talk about condoms, how comfortable are each of you? What do you know about the correct way to use a condom?

Appendix VI

Guidelines on prevention of sexual transmission of HIV

The following general guidelines can be used in both individual or group counselling. They may need to be adapted to different local situations.

Recommendations to all people

If you can be absolutely sure that you have a mutually faithful relationship with your sexual partner, if you are both HIV-negative, and if neither of you is exposed to contaminated blood, (e.g. by intravenous drugs or sharing needles), you are not at risk of sexual transmission of HIV.

If you have sexual intercourse and are not in a mutually faithful sexual relationship, your chance of acquiring HIV infection is influenced by the following three factors.

(1) The choice of your sexual partner(s). The risk of infection depends on whether your partner is infected or not. Because you cannot tell by looking at someone whether they are infected, you must always use condoms.

(2) The number of sexual partners. The greater the number of sexual partners you have, the greater the risk of infection. Therefore reduce the number of sexual partners to the greatest extent possible. You do not always know the sexual behaviours of your partners, so simply reducing the number of partners is not by itself enough. You must still practise protected sex with all partners.

(3) The type of sexual behaviour practised. Abstinence is the best way to prevent sexual transmission. However, for many people this is not acceptable or realistic. The use of condoms and other safer sexual practices are the only ways of decreasing the risk of infection or transmission.

Restriction of sexual contact to activities that do not involve the sharing of semen, vaginal and cervical secretions, or blood (e.g. hugging, caressing) will eliminate the risk of acquiring HIV infection. Other "safer sex" practices include masturbation, massage, rubbing, kissing and hugging. These same precautions are advised for men having sex with men, or women having sex with women. STDs, which facilitate HIV transmission, must be treated. Certain practices may also be more likely to pass on HIV infection when it is present. For example, "dry" sex may lead to breaks in the skin and increase the possibility of HIV being passed from one person to another.

Recommendations to HIV-infected persons

Inform former and current sexual partners about your HIV infection and recommend that they visit a testing centre or health-care provider for counselling and testing. If you are unwilling to notify them personally, request the assistance of counsellor or your care-provider.

Inform potential sexual partners of your HIV infection and restrict sexual contact to safer sex activities only (see above). Always use a condom when engaging in either oral, vaginal or anal sex.

Strictly avoid sexual intercourse when you or your sexual partner have an infection or lesion in the genital, anal, or oral area and during menstruation.

Before deciding to become pregnant or to make someone else pregnant you should bear in mind the fact that the risk of transmission of HIV to the unborn child is approximately 1 in 3. You should also discuss with your partner the danger of unprotected vaginal intercourse before making decisions about future pregnancies.

Do not donate blood, plasma, semen, breast milk, body organs, or other tissues.

Mothers should seek the advice of a counsellor before deciding whether or not to breast-feed.

Recommendations to sexual partners of known HIV-infected persons

Contact a health-care provider for counselling and testing. If the test is negative and you are healthy, and if the last unprotected sexual or needle-sharing exposure to your infected partner was six or more months ago, it can generally be assumed that you have not acquired HIV infection from that exposure. If your last exposure was less than six months ago, a repeat test will be necessary. If you were negative on the initial test, see the recommendations below.

Avoiding unprotected sexual intercourse with an HIV-infected person and restricting contact to safer sex activities are the only ways to reduce the risk of HIV infection.

Avoid all sexual intercourse when either you or your sexual partner has an infection or lesion in the genital, anal, or oral area and during menstruation.

If you are pregnant, seek counselling and testing. If you are found to be HIV-positive, continue counselling to explore the potential health risks to you and your unborn child.

Do not donate blood, plasma, semen, breast milk, body organs, or other tissues.

Appendix VII

Instructions for condom users

For maximum protection, condoms must be used correctly. The following instructions should be given to condom users:

- store condoms away from excessive heat, light, and moisture. These cause them to deteriorate and perhaps break;
- use latex condoms. Animal membrane (e.g. lambskin) condoms are not as effective a barrier against HIV;
- make sure condoms are of good quality, are intact (i.e. without holes or tears) and are not sticky or brittle;
- use a new condom every time you have intercourse;
- always put the condom on the penis before intercourse begins;
- put the condom on when the penis is erect;
- in putting on the condom, squeeze the nipple or empty space at the end of the condom to remove the air from the end of the condom. Do not pull the condom tightly against the tip of the penis; leave the small empty space (1 or 2 centimeters) at the end of the condom to hold the semen;
- unroll the condom all the way to the base of the penis;
- if the condom tears during intercourse, withdraw the penis immediately. Both partners should wash with plain water (women should not douche). Put on a new condom;
- after ejaculation, withdraw the penis while it is still erect. Hold on to the rim of the condom as you withdraw, so that the condom does not slip off;
- remove the condom carefully so that semen does not escape. Dispose of used condoms in a closed receptacle for waste;
- if a lubricant is desired, use a silicone or water-based one, since oil-based ones (e.g. petroleum jelly) may damage condoms.

Appendix VIII

Precautions for the home, school and workplace

- If blood from a person infected with HIV is spilt in the home, school or workplace, it should be cleaned up with an absorbent material (such as a cloth, rag, paper towel, or sawdust), while avoiding direct skin contact with it.
- Household (rubber) gloves should be worn, if available, when cleaning up blood spills. If gloves are not available, another barrier such as a large wad of paper towels should be used to protect against direct skin contact with the blood.
- The blood-soaked absorbent material should then be disposed of either in a plastic bag, burned in an incinerator, or buried.
- The area that was contaminated with the blood should then be washed with a disinfectant (preferably sodium hypochlorite, or household bleach, diluted 1:10 with water) to clean up any excess blood.
- Hands should always be washed with soap and water after cleaning up blood or other body fluids.
- Clothes or cloths that are visibly contaminated with blood should be handled as little as possible. They should be placed and transported in leak-proof bags.
- Such items should be washed with detergent and hot water [at least 71°C (160°F)] for 25 minutes, or if in colder water [less than 70°C (160°F)] with a detergent suitable for cold-water washing.
- Disposable sanitary towels and tampons on which menstrual blood has been spilt should be disposed of immediately after use. If cloth or material is used for menstrual blood these should be wrapped in plastic or paper and washed separately from other clothes.
- Bandages and other dressings soiled with HIV-infected blood should be similarly disposed of. If they cannot be placed in tied plastic bags, they should be burned or buried.

Appendix IX

Precautions for health-care workers

HIV transmission is normally only through blood, semen, and vaginal secretions. However, HIV has also been isolated from saliva, tears, breast milk, cerebrospinal fluid, amniotic fluid, and urine, and is likely to be present in other body fluids, secretions and excretions. As a result, every attempt should be made to use universal precautions in the care of all patients, especially those in emergency-care facilities, where the risk of direct contact with blood is increased and where a patient's HIV status is usually unknown.

- All health-care workers should, when possible, use barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids may occur. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients, for handling articles or surfaces soiled with blood or body fluids, and for performing venepuncture and other vascular access procedures. Gloves should be changed or washed after contact with each patient.

- Masks and protective eye wear or face shields should be worn to prevent exposure of the mucous membranes of the mouth, nose, and eyes during procedures that are likely to release drops of blood or other body fluids. Gowns or aprons should be worn during procedures in which splashes of blood or other body fluids are likely.

- Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. They should be washed again after gloves are removed.

- All health-care workers should take precautions to prevent injuries from needles, scalpels and other sharp instruments or devices used during medical procedures, when cleaning used instruments, and during disposal of used needles.

- After they are used, disposable syringes and needles, scalpel blades and other sharp items should be placed in puncture-resistant containers for disposal.

- Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which there is likely to be a need for resuscitation.

- Health-care workers who have open lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition clears.

These precautions, while important, may be difficult to implement. For example, there may be no sterilization equipment, disposable syringes, aprons, gloves or fuel for sterilization. Managers of health care facilities must then find other ways of protecting those who care for patients, regardless of the patients' HIV status. Discussions among health-care workers on alternative available precautions will be useful.

Counselling after exposure

If a health-care worker has a small percutaneous (e.g. "needle stick" or cut) or mucous membrane (e.g. splash to the eye or mouth) exposure to blood or other body fluids, skin exposure to large amounts of blood, or prolonged contact with blood, especially when the exposed skin is chapped, abraded, or inflamed, the source patient should be told and given a blood test for HIV infection, after consent has been obtained.

If the source patient has AIDS, is HIV-infected, or refuses the test, the health care worker should be offered counselling and testing. A test at this stage will only help to document the health worker's HIV status before exposure to the patient's blood. However, this is important in deducing whether a subsequent seroconversion could be due to this exposure.

Health-care workers who have been exposed to blood or other body fluids should be advised to report and seek medical examination for any acute febrile illness that occurs within the next 12 weeks. If the HIV test soon after exposure is negative, the health worker should be advised to return after about 3 to 6 months for a repeat test. The counsellor should, however, discuss with the exposed health worker the need to adopt or maintain safer sex during the interim period in order to avoid exposing the health worker's sexual partner to infection (in case the health worker is in the "window period").

The health worker is bound to be worried during this period and these worries should be addressed non-judgementally, even if they do not appear to be realistic. If the HIV test soon after exposure (or afterwards) is positive, the health worker should receive ongoing counselling and medical care, as and when necessary. Since the testing of a health worker at any stage has a chance of revealing a positive HIV status, strict confidentiality should be maintained throughout.

Recommendations for health-care workers

GPA's guidelines on the prevention of sexual transmission of HIV contain the following recommendations for health-care workers:

- Be aware of, and sensitive to sexual behaviours that place people at risk of HIV infection.
- Educate others about HIV transmission and its prevention, including, as appropriate, instructions on correct condom use.
- Refer people at increased risk of HIV infection to counselling and testing services.
- Where resources and programmes exist, be prepared to provide additional support through counselling, peer-support groups and other services for HIV-infected persons and their sexual partners, or at least refer such persons to public health or other medical facilities for follow-up.
- Urge HIV-infected people to take the necessary measures to prevent HIV transmission to others and support them in their efforts to do so.
- Assist HIV-infected and non-infected users of intravenous drugs to obtain treatment for their addiction and to avoid sharing needles and drug-injecting equipment.
- Inform pregnant HIV-infected women about the potential health risk to themselves and their unborn child, and provide counselling opportunities. Similar information and counselling should be provided to all HIV-infected women in the childbearing age group.

Appendix X

What counsellors should know about HIV/AIDS

Counsellors must know the basic facts about the transmission and epidemiology of HIV infection, AIDS and related diseases. As knowledge about HIV/AIDS is expanding rapidly, counsellors may find it hard to keep up to date. If so, they should be aware of the limits of their knowledge and be encouraged to seek additional resources and/or training provided by their national AIDS programmes.

The information presented here will be familiar to some counsellors, and useful primarily for review purposes. For others, however, it will be new, and doubtless, insufficient (please refer to the list of other GPA documents on page 86). Whether the information is familiar or not, counsellors need to think about how they would talk about symptoms and infections to people from their own country or region, and to persons from a variety of cultural backgrounds and traditions.

The HIV/AIDS pandemic

In 1981, a new syndrome, the acquired immunodeficiency syndrome (AIDS), was first recognized among homosexual men in the USA. By 1983, the etiological agent — the human immunodeficiency virus (HIV) — had been identified. By the mid-1980s, it became clear that the virus had spread, largely unnoticed, throughout the world and that its effects had reached truly global or "pandemic" proportions.

The HIV/AIDS pandemic consists of many separate epidemics (in many cases, even within a single country). Each epidemic has its own distinct origin, in terms of geography and specific populations affected. It involves different types and frequencies of risk behaviours and practices — for example, having unprotected sex or sharing drug injection equipment.

The extensive spread of HIV appears, in retrospect, to have commenced in the late 1970s or early 1980s. In the Americas, Australia and Western Europe, it involved primarily homosexual or bisexual men and injecting drug users in certain urban areas. In parts of the Caribbean and East and Central Africa, it was more common among men and women with multiple sex partners. Today, the virus is being transmitted on all continents. As of late-1994, more than 18 million HIV infections are estimated to have occurred since the beginning of the pandemic (see Figure 2).

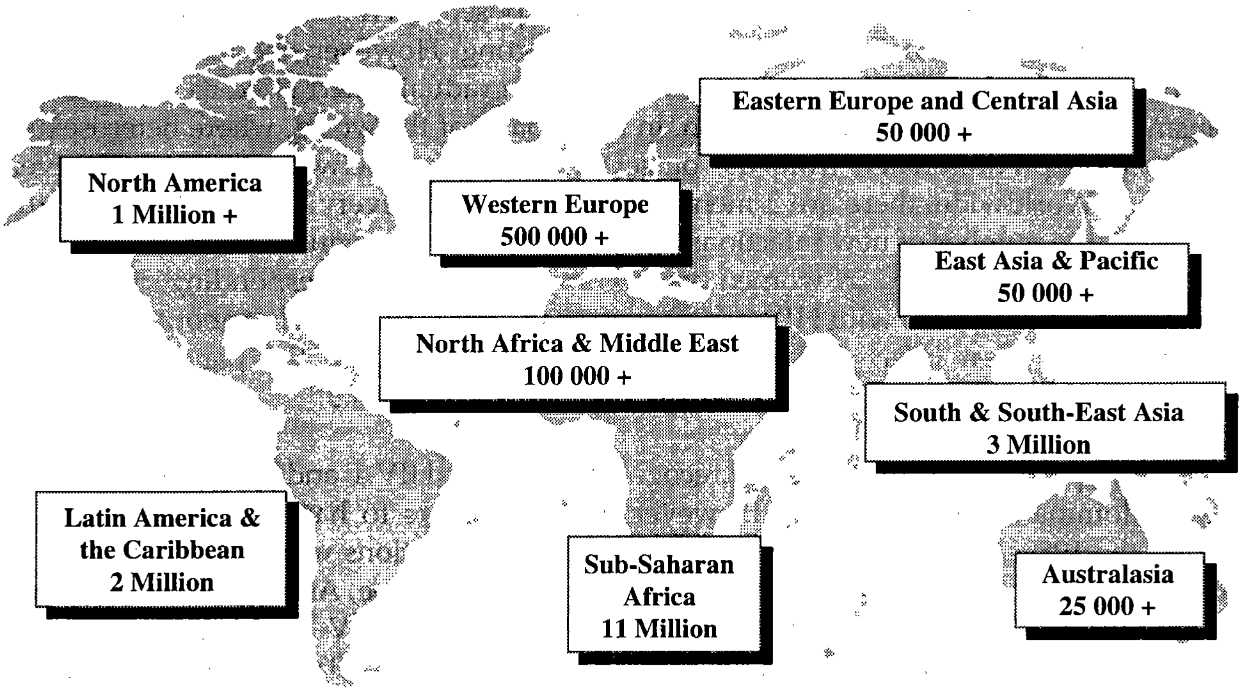
The HIV/AIDS pandemic, although initially centred in urban locations, is now thought to be present in the rural areas of most countries as well. The precise nature and extent of HIV spread in these areas varies between, and even within, individual countries and is largely influenced by the transportation infrastructure.

Initially, in developed countries, men were more exposed to HIV than women, primarily as a result of homosexual intercourse or drug injecting. However, the difference in the numbers of men and women infected with HIV has gradually narrowed as heterosexual transmission has become more common. In other parts of the world, where heterosexual transmission predominated from the outset, the difference between the sexes is even narrower. Worldwide, there are 3 men already infected for every 2 women and, by the year 2000, the number of new infections among women will be equal to that among men. The rising infection rates in women are accompanied by a corresponding rise in the number of children born with HIV infection. To date, it is estimated that about 1,5 million children have been infected with HIV since the beginning of the pandemic. These children rapidly develop AIDS and die, usually before the age of 5.

Two serotypes of HIV are currently recognized, namely HIV-1 and HIV-2. Worldwide, the predominant virus is HIV-1. However, HIV-2 appears to have spread extensively during the 1980s, principally in West Africa. Sporadic infections with this serotype have now been reported from East Africa too, as well as from Europe, Asia and Latin America. The modes of transmission of HIV-2 are similar to those for HIV-1, and the two viruses appear to cause clinically indistinguishable AIDS. However, HIV-2 may be less easily transmitted, and the period between initial infection and illness may be longer in the case of HIV-2.

As of 31 December 1994, 1 025 073 cumulative AIDS cases in adults and children had been reported to WHO. However, WHO estimates that, as of end-1994, allowing for under-diagnosis, under-reporting, and delays in reporting, there have been more than 4.5 million cumulative AIDS cases worldwide.

Figure 2. **Estimated global distribution of total adult HIV infections from late 1970s/early 1980s until late-1994**



Global Total: 18 million

Modes of HIV transmission

It has now been established, as a result of laboratory and epidemiological investigations, that HIV is transmitted in three ways:

- through sexual intercourse,
- through blood, and
- from mother to child.

Sexual intercourse accounts for about three-quarters of all HIV infections worldwide. In other words, HIV infection is a sexually transmitted disease (STD). Transmission through intercourse between men occurs in most parts of the world, although the majority of the world's infections have been acquired through intercourse between men and women (heterosexual transmission).

As with certain other STDs, HIV infection can also be transmitted through blood, e.g., as a result of the medical transfusion of infected blood or blood products. In many parts of the world, progress towards a safer supply of blood and blood products is being achieved through the appropriate selection of donors, the screening of donated blood, and through more rational use of blood aimed at decreasing the number of people being transfused. Less commonly, HIV is also transmitted through the use of non-sterilized skin-piercing instruments, both in health facilities (nosocomial transmission, mostly occurring from patient to patient) and outside the health care setting.

A major problem in both the developed and developing world is HIV transmission resulting from the use of contaminated injection equipment by drug users. Drug use is always expensive, and some drug injectors may engage in prostitution to obtain the money they need for drugs. Combining drug use with prostitution is particularly dangerous for both the prostitute and the client. Special care is needed in counselling those thought to be doing this, in regularly providing condoms, and in encouraging them to insist on their use.

The transmission of HIV from mother to child includes transmission during pregnancy, during delivery and through breast-feeding. Overall, approximately one-third of children born to HIV-infected mothers will be infected with HIV. Much of mother-to-child transmission occurs during pregnancy and delivery, although recent data suggest that up to 15% of babies breast-fed by HIV-infected mothers may become infected by breast-feeding.

Laboratory and epidemiological studies have also shown that HIV is <u>not</u> transmitted by everyday contact, by hugging or kissing, through food or water, or by mosquitos and other biting insects. HIV, like other viruses, is easily destroyed by boiling and steaming (autoclaving). The virus can also be destroyed by various chemicals used in standard disinfectants (hypochlorite, glutaraldehyde and formaldehyde), normally recommended for hepatitis B virus, as well as by alcohols, acetone, phenol, and several detergents.

However, the lipid envelope can protect the virus from dehydration. This means that contaminated fluid which has been allowed to dry may still contain infectious virus for hours or even days if kept at room temperature. It is important, therefore, to ensure that any surfaces or clinical instruments contaminated with body fluids are treated with effective disinfectants.

Progression from HIV infection to illness

HIV selectively infects specific white blood cells (CD4) that are an essential part of the body's immune defence system. When the CD4 cells are destroyed, the infected person becomes susceptible to a range of opportunistic infectious diseases and cancers. AIDS is the term applied to a group of such conditions, the presence of which indicates severe damage to the immune system. HIV may also directly infect nerve cells and cause neurological disorders.

AIDS stands for:

Acquired = not inborn, passed from person to person, including from mother to baby
Immune = body's defence system
Deficiency = not working properly
Syndrome = a group of signs and symptoms

The interval between infection with HIV and the onset of clinical symptoms is unusually long compared with other communicable diseases, and varies considerably between individuals. An acute HIV syndrome, associated with seroconversion, can occur as early as a few weeks after the infection is acquired. The typical clinical manifestations in the acute phase are fever, lymphadenopathy, night sweats, skin rash, headache, and cough. Studies have shown that only a minority of persons who seroconvert have such acute symptoms. The period before the development of an antibody response, usually between 2-12 weeks, is often referred to as the "window period", when the person is infectious but is not positive in HIV-antibody tests. Approximately 50% of those infected become ill within ten years of initial infection. Current evidence suggests that, in the absence of other causes of death, almost all HIV-infected people will ultimately die of AIDS. Once an individual develops AIDS, the average survival time may be as short as 6 months or as long as 2 years or more.

AIDS results from infection with HIV and consequent damage to the immune system. The damaged immune system cannot protect the body against certain other infections and cancers, some of which then become the direct causes of death. These illnesses include:

- Chest conditions such as tuberculosis, *Pneumocystis carinii pneumonia* (PCP) and other pneumonias;
- Chronic diarrhoea;
- Skin conditions, including shingles (herpes zoster) and fungal infections;
- Recurrent fever;
- Kaposi sarcoma and other cancers;
- Mouth and throat problems, e.g. oral thrush;
- Mental problems, including dementia.

Less is known of the natural history of HIV-2 infections, although the evidence to date suggests that people infected with HIV-2 progress to AIDS considerably more slowly than those infected with HIV-1.

Several factors may influence the rate of progression from HIV infection to onset of clinical illness. Some strains of HIV may be more pathogenic than others. Human genetic factors and other host-specific factors may affect the rate at which different individuals develop disease. Yet other factors, including concurrent infections, may also play a role. There is clear evidence that young children and adults over 40 years of age progress to disease faster than young adults.

Interactions between HIV infection and other diseases

The transmission of other sexually transmitted diseases (STDs), including gonorrhoea, syphilis and chancroid, is associated with the same behaviours that expose individuals to potential HIV infection and ultimately AIDS. Furthermore, data suggest that STDs, both ulcerative and non-ulcerative, greatly facilitate both the acquisition and transmission of HIV. For both these reasons, effective STD diagnosis, care and education are imperative for the prevention of HIV infection. For guidelines, please see WHO's publication, *Prevention of sexual transmission of human immunodeficiency virus* (WHO AIDS Series, N° 6).

About 30% to 50% of adults in most developing countries have latent tuberculosis infection, i.e. they have been infected with *Mycobacterium tuberculosis* at some point in their lives, but have not developed active tuberculosis. Tuberculosis is already one of the leading causes of adult death in many developing countries, killing around 3 million people a year. An alarming increase in cases has been reported in parallel with the AIDS epidemic in many countries. HIV infection is now the strongest known risk factor for the development of active tuberculosis. People with latent tuberculosis infection more readily develop the disease once their immune system has been damaged by HIV. As many as 10% of these dually infected people may develop active tuberculosis each year.

With regard to immunization, studies have demonstrated that the use of the following immunizations is safe in children suspected of being infected with HIV-1: tuberculosis vaccine (BCG); diphtheria and tetanus toxoids and pertussis vaccine (DTP); live oral poliovirus vaccine (OPV); inactivated poliovirus vaccine (IPV) and measles vaccine (all the standard immunizations recommended for children). However, BCG should not be used if a child has symptoms of HIV-related disease. Yellow-fever vaccine is recommended for asymptomatic HIV-positive individuals. Safety in symptomatic HIV-positive persons is unknown. The safety of other live vaccines has not been evaluated. In general, where there is a high prevalence of HIV infection, asymptomatic persons should continue to be immunized in accordance with the standard schedules recommended by the WHO Expanded Programme on Immunization. Further experience continues to support these recommendations, highlighting the benefits of immunization in protecting HIV-1-infected children, particularly against measles and the complications of tuberculosis.

Treatment of HIV/AIDS

People with HIV infection or disease usually seek or request information about treatment and possible cures. It is therefore important for counsellors to receive regular and reliable updates on the progress of research, together with information about the availability and effectiveness of specific drugs or therapies for HIV-related conditions. While there is as yet no cure for HIV infection or for AIDS, some therapies have been found to be effective in treating opportunistic diseases arising from immunodeficiency. A few drugs have been able to inhibit the multiplication of HIV in infected people. These drugs do not eliminate the virus from the body but may be useful in prolonging life in patients who are infected with HIV. More than 40 different drugs (antivirals and immunomodulators) are currently being tested separately or in combination in more than 100 clinical trials, mainly in industrialized countries.

It is also important to recognize that many people may mistake expensive treatment or care for good treatment. Counsellors should be aware of this and help patients make decisions on the advantages and disadvantages of different therapies and interventions.

Glossary *

Client: The person seeking or receiving HIV counselling and/or testing. In the case of a child or other person unable to consent to testing on his/her own behalf, the client is the parent or other adult with the ethical and legal competence to do so.

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

Pre-test counselling: Dialogue between a client and a care provider aimed at discussing the HIV test and the possible implications of knowing one's HIV serostatus, which leads to an informed decision to take or not take the test.

Post-test counselling: Dialogue between a client and a care provider aimed at discussing the HIV test result and providing appropriate information, support and referral, and at encouraging risk-reduction behaviours.

Testing:

1) Laboratory testing, i.e. application of an assay (e.g. ELISA) for laboratory markers of HIV infection such as HIV antigen or antibodies. The assay may be used in order to screen blood for transfusion, or organs or tissue for transplantation (see **screening**), or in order to test an individual (see **testing 2)**).

2) More broadly, the testing of individuals with the intention to determine their HIV infection status. All testing in this sense can be categorized according to three sets of criteria:

    a) client-initiated, health-care provider-initiated, or initiated or required by a third party for other than health purposes;

    b) with or without informed consent; and

    c) anonymous, confidential, or non-confidential. These terms are defined below.

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* Source: Statement from the Consultation on Testing and Counselling for HIV Infection, 16-18 November 1992, Geneva, WHO/GPA/INF/93.2.

Client-initiated testing: HIV testing requested by a client on his/her own initiative.

Health-care provider-initiated testing: HIV testing initiated by the client's health care worker.

Testing initiated or required by a third party for other than health purposes: HIV testing for other purposes, such as immigration, employment or insurance.

Testing with informed consent: HIV testing performed only after the client has given informed consent to it. **Informed** in this context means that in discussion (pre-test counselling) the client has been made aware of all the ramifications of HIV testing, including the risks and benefits, as well as of alternatives to such testing, in language he/she can understand. **Consent** means the giving of express agreement to HIV testing in a situation devoid of coercion, in which the client should feel equally free to grant or withhold consent.

Testing without informed consent: HIV testing in which informed consent, as defined above, has not been requested and given.**

Mandatory testing: HIV testing without informed consent which the individual is compelled to undergo. The term refers both to situations in which the individual clearly has no alternative - as when prisoners are tested involuntarily - and to situations in which refusal of testing is not realistic or would cause the individual undue hardship, as when HIV testing is required prior to employment or marriage.

Anonymous testing: HIV testing in which the blood sample and test result are identified only by code, not by name, with no personal identifiers to link the sample to the donor source.

Linked anonymous testing: HIV testing in which the code is known only to the client.

Unlinked anonymous testing: HIV testing (e.g. for surveillance purposes) after prior removal of all personal identifiers, so that retrospective identification is impossible.

Confidential testing: HIV testing in which only the client and the health professionals involved in the client's direct care know that the test was performed and have access to the test results. This information is not furnished under any circumstances to other health care providers, health authorities, employers, insurers, schools or other third parties without the patient's explicit consent.

** "Routine testing" is sometimes used to mean the HIV testing of individuals without their knowledge or unless they specifically refuse such testing. Examples are routine testing policies applied by hospitals to patients, and sometimes applied to people attending antenatal or STD clinics. This term should not be used because it does not specify whether informed consent is requested and granted.

Non-confidential testing: HIV testing conducted neither anonymously nor confidentially.

Voluntary testing: Anonymous or confidential testing initiated by either the client or his/her health care provider and performed with the client's informed consent.

Screening: The systematic laboratory testing of donated blood, blood products, tissue (including sperm) and organs for the purpose of preventing HIV transmission to the recipients. Other specimens, such as saliva, may also be used.

Relevant material available through WHO's Global Programme on AIDS

Already issued:

Statement from the Consultation on Testing and Counselling, 16-18 November 1992. WHO/GPA/INF/93.2.

Guidelines for the Clinical Management of HIV Infection (adults and children). WHO/GPA/IDS/HCS/91.6 and WHO/GPA/IDS/HCS/93.3.

NAP Programme Management Training Course Module on HIV/AIDS Care and Social Support (WHO, 1993).

AIDS Home Care Handbook. WHO/GPA/IDS/HCS/93.2.

HIV Prevention and care: Teaching Modules for Nurses and Midwives. WHO/GPA/CNP/TMD/93.3.

Living with AIDS in the Community. WHO/GPA/IDS/HCS/92.1 Rev.1.

Guidelines for Blood Donor Counselling on Human Immunodeficiency Virus (HIV). WHO/GPA/TCO/HCS/94.2

To be issued:

HIV/AIDS Counselling, A Key to Caring — Guidelines for Policy Makers and Planners (WHO AIDS Series, N°8).

Guidelines for Implementing HIV/AIDS Counselling

Guidelines on Breast-feeding and HIV.

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