HIV/AIDS/STD
COUNSELLING TRAINING MANUAL

National AIDS Control Organization
(*Ministry of Health & Family Welfare*)
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CONTENTS

ACKNOWLEDGEMENT

1. Alka Bhuttan, Nurse Counsellor, All India Institute of Medical Sciences, New Delhi

2. Vineeta Chitale, Lecturer, Department of Medical and Psychiatric Social Work, Tata Institute of Social Sciences, Bombay.

3. Shankar Choudhary, Department of Community Medicine, All India Institute of Medical Sciences, New Delhi.

4. Jacob John, Professor, Department of Psychiatry, Christian Medical College, Vellore.

5. Saroj Jha, Ag. Regional Adviser, WHO/SEARO, New Delhi

6. Sujata DeMagry, Director, INSA, Bangalore

7. Vimla Nadkarni, Head, Department of Medical and Psychiatric Social Work

8. Nalini Sahay, Deputy Director (IEC), NACO, New Delhi

9. Kusum Sehgal, Consultant in Counselling for NACO, New Delhi

10. Chitra Subramaniam, HIV/AIDS Counsellor, Bombay

ADDITIONAL RESOURCE PERSONS

11. Rajiv Dua, Faculty, Department of Medical and Psychiatric Social Work, Tata Institute of Social Sciences, Bombay

12. Jasmeet Kaur, Counsellor, Bombay

13. Phani Prabha Kumar, Counsellor, Bombay

14. Carol Larivee, Health Education Specialist, WHO/GPA, New Delhi

15. Geeta Sethi, Consultant, NACO, New Delhi

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FACILITATORS GUIDE
WORKSHOP OBJECTIVES AND DESIGN

INTRODUCTION

Counselling is an important component of all AIDS/STD control programmes because of the nature of HIV infection and transmission. There are no simple solutions to this new and complex pandemic. For this reason, both this Manual and the training workshops for which it is intended are designed to explore different approaches and to make all those responsible for counselling aware of the need for psychosocial support, prevention and resource mobilization as components of a holistic approach in AIDS prevention and control.

Supporting persons with AIDS and preventing further spread of the disease will require long-term efforts on the part of many individuals and specialities within the country. These efforts must be effectively managed and in some cases will require new skills on the part of existing personnel. In order to augment the skills available within the country for counselling, NACO has developed this HIV/AIDS Counselling Training Manual to help trainers who are asked to organise training programmes for HIV/AIDS counsellors. The various modules are designed to upgrade the skills of practicing individuals and those interested in providing counselling services to the HIV infected.

Generally speaking, HIV/AIDS counselling training workshops have two major themes:

- counselling for prevention of HIV transmission;
- counselling for support of those affected by HIV.

Both of these themes are presented within a "psychosocial perspective" that views clients in relation to other people, and never as isolated individuals. A "psychosocial perspective" ensures that counsellors will help their clients to become aware of their own resources and strengths as well as their fears, and of the potential support from other groups of people like family, friends and others, and related health care services. Having completed the programme, the trainees should be encouraged to practice the skills they have learned over a significantly long period. The counselling they do may be in their work place, in a health facility or in their community.

This Manual has been designed for use in India. It comprises of 6 modules. To each module is annexed Trainer resource material.

During the workshop, participants will be expected to do a certain amount of reading. While textbooks and training manuals are useful, they are not sufficient in counselling training. Counselling is a complex and active procedure, and can be learned only through practice and dynamic interaction. However, the Manual can be used as an overall guide in training workshops. It provides the basis for discussions about various aspects of preventive counselling, presents a variety of counselling approaches, and provides basic information on counselling techniques. Participants should be urged to read and reread the Manual sections assigned before each meeting of the working groups.

They should also asked to remember throughout that the words of the Manual will be translated into action and counselling skills only if they participate actively in the workshop and take the steps which, they as counsellors with some degree of training, will shortly be asking their clients to take.

In short, a workshop should be organized on the assumption that counselling is learned by doing. Trainees attending a counselling workshop inevitably bring with them a mixture of expectations and anxieties about the experience, but these should not be allowed to interfere with the contributions they can make to the workshop or with what they can learn from it. How much is learned will depend on the degree of openness, involvement in activities, risk-taking with colleagues and the facilitator, as well as a careful examination of personal values, prejudices and beliefs.

SPECIFIC TEACHING OBJECTIVES

At the conclusion of a training workshop, each participant should be able to :

1. Describe the various levels of preventive counselling, and to discuss clearly, factually, and confidently with persons waiting (HIV-infected persons, persons at risk, family members, and people in the community) to know how to prevent infection, means of transmission, necessary changes in behaviour, forms of "safer sex" and "safer drug use", beliefs and fears about infection and illness, and the potential personal and social consequences of a diagnosis of AIDS.

2. Discuss the concerns and issues related to risk reduction, pre-test and post-test counselling, and identify the ethical and practical difficulties involved.

3. Build on and update information about the physical and psychosocial needs of people who fear that they may be infected and of HIV-infected people.

4. Select and adapt culturally appropriate counselling techniques and communication styles.

5. Identify and discuss their personal attitudes and feelings about sexuality which make the counselling process easier or more difficult for them to conduct.

6. Identify and mobilize both informal and formal human and material resources in the community for prevention, support and control.

7. Apply knowledge of the legal and ethical issues involved in testing, partner notification confidentiality and informed consent.

8. Address issues of HIV/AIDS infected individuals in long term care, e.g. problem solving, decision making and care of the terminally ill.

9. Be aware of special needs of certain groups (IVDUs, women, children, and individuals in non-heterosexual relationships).

THE TARGET AUDIENCE

This manual has been designed for individuals who are trained in either Social Work or Psychology. This manual provide further training in HIV/AIDS counselling in order to train other health care providers. Therefore this manual is to be used for training of trainers. The trainees could be health professionals who are dealing with HIV/AIDS in their work or health workers from both governmental and non-governmental organisations interested in developing skills in counselling. Trainees may also include staff of de-addiction centres, teachers etc who need to learn more about HIV/AIDS to assist them in their current work or in community development programmes. Those dealing with STD cases in their work would also find this Manual helpful. Group size should be a maximum of 20 participants.

OVERVIEW OF THE MANUAL

This manual gives counselling trainers, counsellors, health care workers and others involved with HIV/AIDS-related work a model for HIV/AIDS counselling training. This model can be adapted to local needs and circumstances for use in training those who will subsequently provide counselling to those affected both directly and indirectly by HIV infection and disease.

This manual is intended to be used in training workshops and is designed for two purposes. These include:

- Training of trainers. In this course, participants who are already practising counselling are provided with new skills specific to HIV counselling; and, more importantly, trained to act as trainers in similar workshops. The trainers are then encouraged to adapt the educational material to socio-cultural circumstances and to provide skills to local formal and informal health and social workers, involved in HIV/AIDS related work.

- Training of formal and informal health and social workers in counselling skills relevant to their level of knowledge and local conditions.

Small group exercises have also been designed and included to facilitate this process while at the same time promoting group cohesion and direction. These exercises should be regarded as a core component of the training process, be reasonably informal, and be adapted as appropriate to specific settings and cultures.

ORGANISATION/CONTENT OF THE MANUAL.

The Manual is designed to be used as a series of separate modules. The modules may be used in any number and order, depending on the aims, the participants of each training workshop, and the time available for training. Each of these modules includes activities. These activities are the "core" of the training workshop for which the Manual is designed - they raise and explore issues in the modules in an experiential and challenging but non-threatening way.

In order to achieve the training objectives, six modules have been identified and developed in this Manual. These are:

Module 1 : HIV/AIDS/STD Information

This module seeks to raise the trainee's awareness and to improve their knowledge of HIV/AIDS. It seeks to help them understand and perceive the risk situations that lead to HIV infection and sexually transmitted diseases.

Module 2: Value, Attitudes and Cultural issues.

This module deals with the response of the community to the AIDS pandemic, the ways in which cultural attitudes and beliefs of infection are influenced by this response, the role of trainees in decreasing these effects and strengthening community resources. In order to sensitise the trainees to the complex psycho-social ramifications of HIV/AIDS it is essential to help them clarify their own feelings and attitudes toward HIV/AIDS related issues.

Module 3 : HIV/AIDS Counselling, Principles, Skills and Methodology.

This module deals with HIV/AIDS related counselling. Trainees are not only made familiar with the principles and goals of counselling, but they are also exposed to the skills needed in preventive and supportive counselling with regards to HIV/AIDS. This module also covers legal and ethical issues in HIV/AIDS counselling.

Module 4 : Psychological Issues and Sexuality.

This module seeks to provide a conceptual clarity on myths and facts about sexuality. Trainees will be given opportunities to develop competence to discuss the issues regarding sexuality without embarrassment. Trainees will also be made aware of the various psychological issues that arise with regards to an HIV infected individual.

Module 5 : Special Issues.

This module seeks to expose trainees to the various issues that arise while working with special groups of people. This module aims to make the trainees aware of the counselling needs of women, children, substance users and individuals in non-heterosexual relationships.

Module 6 : Staff Support, Networking and Documentation.

This module seeks to sensitise trainees of the importance of staff support, networking and documentation. Counselling can be challenging and problems can arise. This module offers strategies to trainees so that they can develop skills in staff support, networking and documentation.

The manual contains Appendix 1 which give practical advice and information for people with HIV infection or disease and Appendix 2 which gives practical information on universal health precautions.

SUMMARY

In training workshops for HIV-AIDS counsellors, the emphasis must be on learning counselling by doing it rather than through passive listening or formal study. Small working groups must be established for this purpose, since such groups provide effective means of active learning. Ideally each such group should be assisted by two facilitators, one of whom is a trainer and the other could be a counsellor or co-trainer familiar with local or regional conditions.

EVALUATION

No training programme is complete without evaluation. The areas to be evaluated can be briefly summarised as pertaining to the trainer/training/trainee.The trainee-specific areas to be evaluated are broadly knowledge, attitude and skills.

Various methods of evaluation are available, particularly relating to knowledge and attitudes. Skills are more difficult to evaluate and involve methods that are often cumbersome, expensive and time consuming but equally important.

It is desirable to have trainees evaluate the usefulness and applicability of each section as well as the efficacy of the trainer in dealing with it. One such format is available at the end of this module Evaluation of some of the skills, for example making the client feel at ease, using open-

ended questions, active listening, supportive statements, etc. is also important. However this may be better done during follow up contact programmes rather than immediately after the first training. Evaluation of counselling activities, management and professional issues are also possible. However, this is not being recommended at this stage.

Follow up training

Orientation and some basic skill building for counselling is only the first step. Counsellors need the opportunity to practice their skills over a period of time. Not only is practice needed, but also the opportunity to discuss how they are doing with a supervisor or a colleague, and sharing new or different ideas with other counsellors. As a trainer it is crucial that this important stage of training to become a counsellor is recognised and encouraged.

Some counsellors may want to participate in more training to develop the skills to counsel more difficult cases, or where they are spending a lot of time counselling and need more skills. This is a further stage of training for which different materials and methods are needed.

It would be unrealistic to expect that this Guide would help produce full fledged counsellors at the end of the training period.

Trainees would need to further acquire and refine their counselling skills under supervision and support.

ORGANIZATION OF THE TRAINING WORKSHOP

The training workshop differs from other training courses in that:

- The material in the course will not be presented by lecture. Instead, each participant will be given the manual divided into a set of instruction booklets called modules, that have the basic information to be learned and will participate in a series of activities/exercises which will facilitate learning of the course material.

- The modules are designed to help each participant develop specific skills involved in the emotional support of HIV infected and ill persons and motivating people to reduce their risk of getting infective.

- Each participant is encouraged to discuss any problems or questions with a facilitator, and to receive prompt feedback from the facilitator on completed activities (that is, to be told how well they did the exercise and what improvements could be made).

The first session should focus on a general discussion and understanding of the participants' expectations from the workshop, and their practical experiences in the places from where they come. This helps the facilitator appreciate view points of the participants. It would be important for the facilitator to ask for the trainees doubts and concerns regarding implementation of the various issues covered by this manual in their work settings.

This will increase the impact of the training and encourage participants to work out how they can apply the acquired knowledge and skills to their role as a HIV/AIDS counsellors.

The workshop should start with a series of general discussions aimed at informing participants about the medical, social, psychological and political aspects of the countrywide crisis created by HIV, AIDS and related diseases. Each of the following days should begin with a plenary session designed to review factual information, research reports, or elaboration of themes covered in the Manual the previous date. Each day should end with a review of that day's plenary and group activities and the assignment of reading for the participants (of the chapters that will be covered the next day).

During small group work, it is important for the facilitator to make sure that the groups of participants working together over the course of the workshop in either pairs or small groups, is constantly changing. The facilitator will need to supervise the rotation of the participants so everybody gets to work with everybody in the full group.

Working with co-facilitators

When you are working as a team of trainers, assist one another in providing individual feedback and conducting group discussions. For example, one facilitator may lead a group discussion and the other may record the important ideas on the flipchart.

While one or two facilitators are conducting the activities of a particular module, the other facilitators should be present and not move away or talk among themselves. All the facilitators should be debriefed either at the beginning or at the end of the day so as to:

1. Discuss any problems (for eg. training styles) that may have occured during the day.
2. Prepare and plan for the next day.
3. Support and reinforce each other.

Checklist of supplies and space needed for the workshop

Supplies needed for each trainee include:

- O Name tags with pins
- O Paper
- O Ball point pen
- O Pencils
- O Copy of NACO Counselling Module
- O Condoms to accompany activity.

Supplies needed for the workshop include:

- Flipchart stands with paper and felt pens or blackboard with chalk
- Scotch tape
- Scissors
- OHP and transparencies/OHP sheets
- TV and Video casette player (optional)

Space Required for Workshop:

There should be a very large room for plenary sessions involving the group as a whole. Small group work will require the availability of small rooms. In the best circumstances there should be one small room for each group of 4 to 8 participants. When the rooms for the working groups are close to the plenary room, the working groups can be integrated smoothly and less time is wasted in the process of forming groups and finishing group work.

Use of tables or desks for participants within the large and small rooms must take into account the need for varying seating arrangements for group work. Besides this the furniture should be easily rearranged.

From previous experience with similar workshops, it is recommended that the accommodation and workshop be located together outside a city in the case of the residential workshops. This allows the facilitators and participants to socialize more easily and diminishes the external distractions for everyone.

Suggested Workshop schedule

Encourage participants to arrive the day before the workshop and have a social evening of introductions. A copy of the training manual with only the content should be given to each of the participants with a basic introduction to it. The trainer should have twenty sets of manuals with only the content section xeroxed, to be distributed to each trainee at the beginning of the workshop. These xeroxed manuals should be returned to the trainer at the end of the workshop. On completion of the workshop each trainee should be given the complete manual (including activities and worksheets). The group is expected to read the Modules that are to be addressed next day before the next morning session. Finally, it is hoped that the participants in training workshops will each be given a copy of the Manual and they will use it in their day-to-day work.

It is suggested that the workshop be from 9 a.m. - 5.30 p.m., with a 1-hour lunch break and a half hour tea break for the morning and afternoon sessions. Participants are expected to be punctual for the sessions and present throughout the working hours.

NOTE FOR TRAINERS/FACILITATORS

What is a facilitator?

A facilitator is a person who helps the participants learn the skills presented in the course materials, usually through individual or group discussions. For facilitators to give enough attention to each participant, a ratio of 1 facilitator to each 3 to 6 participants is desired. In your assignment to teach this manual, YOU are a facilitator.

As a facilitator, you will need to be very familiar with the material being taught. It will be your job to answer questions, talk with participants about the exercises, lead group discussions, and generally give participants any help they need to successfully complete the course. You will not be expected to teach the entire content of the course through formal lectures. Hence the experience of and careful planning of experiential exercises (like role plays, simulations etc) is very necessary.

As a facilitator, you should:

- read the modules to be discussed before and work through the exercises,
- plan the schedule for the day,
- plan how the work within each module will be done and what major points you should make,
- think about sections that participants might find difficult and questions that they may ask,
- plan ways to help with difficult sections and to answer possible questions,
- think about the skills taught in the module and how they can be applied in each participant's place of work,
- plan questions to ask participants so that they will also think about how the skills can be applied in their cities and districts,
- Allocate responsibilities and section/exercises among co-facilitators if you are working as a team of trainers so that everyone is clear about their roles and area of work.

How does the facilitator instruct, motivate and guide the participants?

- by demonstrating enthusiasm for the topics covered in the course and for the work that the participants are doing,
- by being receptive to each participant's questions and needs.

As a facilitator, you should encourage the participants to come to you at any time with questions or comments. Always be available during scheduled times, and avoid working on other projects or carrying on discussions not related to the course.

You need to promote a friendly, cooperative environment. You should respond positively to questions (for example, "Yes, I see what you mean," or "That is a good question."). You should also avoid using facial expressions or making comments that ridicule participants.

Always take enough time with participants to fully answer their questions (that is, so that both you and the participant are satisfied). Finally, you should not always wait for participants to ask for help. Instead, watch the participant looking troubled, staring into space, not working on activities, not writing answers, or not turning pages.

Suggestions to facilitators for motivating participants.

How to encourage interaction : During the first day, interact a least once with every participant, and encourage the participants to interact with you frequently. As a response, it is likely that the participants will overcome their shyness, they will realize that you are willing to interact and expect the interaction and will continue to interact with you throughout the remainder of the course.

Look carefully at each participant's work. Check to see if participants are having any problems, even if they do not ask for help. If you show interest and give each participant attention, the participants will feel more motivated to do the work. Also, if the participants know that someone is interested in what they are doing, they are more likely to ask for help if they need it.

Be readily available to the participants at all times; remain in the room and look approachable (for example, do not read magazines or talk constantly with other facilitators).

How to keep participants involved : Frequently ask questions or for reactions of participants to check their understanding and to keep them actively thinking and participating. Questions that begin with "what", "why", "how" require more than just a few words to answer. Avoid asking questions that can be answered by just one word (for example, questions that begin with "Do").

After asking a question, PAUSE. Give participants time to think and formulate a response. A common mistake is to ask a question and then answer it yourself. If no one answers your questions, rephrasing it can help break the tension of silence. But do not do this repeatedly. Sometimes silence is productive and powerful.

Acknowledge all participants' responses. This will make the participants feel valued and encourage them and others to continue to participate. Do this with a comment, a "thank you" or a definite nod. If you think a participant has missed the point, ask for clarification or ask if another participant has a suggestion. If a participant feels his comment is ridiculed or ignored, he may withdraw from the discussion entirely or not speak voluntarily again.

Use names when you call on participants to speak, and when you give them credit or thanks. Use the speaker's name when you refer back to a previous comment.

Always maintain frequent eye contact with **all** the participants so everyone feels included. Be careful not to always look at the same participants. Looking at a participant for a few seconds will often prompt a reply, even from a reticent participant.

Write key ideas on a flipchart as they are offered. This is a good way to acknowledge responses. The speaker will know his/her suggestion has been heard and will have the gratification of having it recorded for the entire group to see.

When recording ideas on a flipchart, use the participant's own words if possible. If you must be more brief, paraphrase the idea and check it with the participant before writing it. You want to be sure the participant feels you understood and recorded his/her idea accurately.

At the beginning of a discussion, write the main question on the flipchart. Having the question visible will help most participants keep themselves on track. When needed, walk to the flipchart and point to the question.

Paraphrase and summarize frequently to keep participants focused on a clear idea and to keep discussions on track. Ask participants for clarification of statements as needed.

Do not let several participants talk at once. When this occurs, stop the talkers and assign an order for speaking, (For example, say "Let's hear Dr. Arun's Comments first, then Dr. Neela, then Dr Lal's.") People usually will not interrupt if they know they will have a turn to talk.

Thank participants whose comments are succinct and to the point.Try to encourage quieter participants to talk. Ask to hear from a participant in the group who has not spoken before, or walk towards someone to focus attention on him/her and make him/her feel he/she is being asked to talk.

TRAINING PLAN OPTIONS

Workshops that are organized using this Training Manual in its complete form would be for a 6 day duration. Alternatively, specific modules can be chosen and used to cover the specific areas if a group of trainees need inputs on certain topics only. The trainer responsible for the workshop should select the relevant modules and activities if the workshop is to be for less than 6 days.

When designing HIV/AIDS counselling training workshops, the trainer should select the modules that are most appropriate to the objectives and learning level of the workshop, then select the relevant activities, and use these materials as required. He/she will also have the responsibility of adapting the activities and the information in the modules if local circumstances and conditions indicate the need to do so.

The present Training Manual can be used for workshops of different time frames i.e. residential programmes, day workshops for workers in the same city or workshops for full time workers. In case the trainees are already trained counsellors and only need to learn the issues and skills specific to HIV/AIDS counselling, shorter workshops can be organised.

Following are some Training Plan Options :

1) A continuous residential workshop of 6 days, covering 1 or 2 modules each day can be organised. It is important to organise some field visits to agencies working in the HIV/AIDS field and to invite experts working in this field for guest talks during the workshop. The evenings can be used to screen films.

2) The workshop can be also conducted as a non-residential workshop for a 6 day duration where the manual is used in it's complete form.

3) The workshops can be phased into 1 day workshops to cover one module at a time where the meetings are once a week and span a period of 6 weeks.

4) Another way to phase the manual-training would be to organise weekend workshops i.e. meetings on Sat-Sun, for 3 consecutive or 3 alternative weekends. However, it is recommended that all the modules should be covered **within 3 months** so as to avoid loss of continuity.

The phased approach is also particularly useful for training social workers, health-care professionals, counsellors, teachers and pschologists who are already working full-time in the same city and may not be able to devote 6 full days for the training.

The phased-workshop approach helps trainees to practice some of the skills learnt in the field before they attend the next session. It is recommended. that trainees are given opportunities to see and work with clients in the health care or community settings during the 2-3 week gap between workshop sessions. They can report back and discuss their cases in the sessions in the next phase.

Trainees must seek field experience of working with 5-6 clients within the 3 months of training so as to strengthen and reinforce the skills learnt during the training. Trainees should maintain case records and submit them to the trainers so that these records can be reviewed by the trainer. If possible the trainee should see the trainer in person for feed back on their case records. In case this is not feasible then the trainees should mail the case records. For field work opportunities trainees should be encouraged to tie up with NGOs, PHCs, Civil Hospitals etc. The trainees should be encouraged to seek the help of the training center or the state AIDS office for information regarding field work opportunities.

WORKSHOP FEEDBACK FORM

1. What are the two most important things you have learned about AIDS and STD?

   _____

   _____

   _____

2. What are the two most important things you have learned about counselling?

   _____

   _____

   _____

3. Your greatest worry about AIDS as an issue is

   _____

   _____

   _____

4. The time period of the worshop was (please circle any one):

   Just right

   Too short

   Too long

5. The handouts and written materials provided were (please circle any one):

   Informative

   Repetitive

   Inadequate or incomplete

   Any suggestions

6.In your opinion was the information covered in each module:

	Useful	Not useful
a. Module 1: HIV/AIDS/STD Information	____	____
b. Module 2: Values, Attitudes and Cultural issues	____	____
c. Module 3: HIV/AIDS Counselling: Principles, Skills and Methodology	____	____
d. Module 4: Psychological Issues and Sexuality	____	____
e. Module 5: Special Issues	____	____
f. Module 6: Staff Support, Networking and Documentation	____	____

7. Which module session did you like the best?

_____

_____

_____

8. The best thing about this programme was

_____

_____

_____

9. The worst thing about this programme was

_____

_____

_____

10. Please rate the Resource Trainers (Please tick one column for each trainee):

Name	Excellent	Good	Fair	Needs more experience
a.				
b.				
c.				
d.				
e.				
f.				
g.				
h.				
i.				
j.				

MODULE 1:
HIV/AIDS/STD INFECTION

EXPECTED OUTCOME

On completion of this module the trainees will have a basic understanding of HIV and AIDS and its relationship with STDs, impact of the pandemic in India and the importance of preventing further spread of infection.

MODULE AT A GLANCE
TOTAL TIME - 3 HRS 55 MINS

CONTENT SECTION

THE NATURE OF THE VIRUS
STAGES OF HIV INFECTION
TRANSMISSION OF HIV
PREVENTION OF HIV INFECTION
SEXUALLY TRANSMITTED DISEASES (STDS)
IMPLICATIONS OF HIV/AIDS IN INDIA

ACTIVITY SECTION

INTRODUCTION	:	15 mins
QUIZ	:	20 mins
CONTENT PRESENTATION	:	2 hours
RANKING EXERCISE	:	30 mins
ROLE PLAY	:	30 mins
REVIEW QUESTIONS	:	20 mins

OVERVIEW

The first cases of AIDS were seen in the United States in 1981 but the virus responsible for the disease was not isolated until 1983. In India, the first HIV positive cases were recorded in April 1986. The virus causing AIDS is known as the Human Immunodeficiency Virus (HIV). HIV infects the CD4 white blood cells; these are an essential part of the body's immune system so that, when they are destroyed, the infected person becomes susceptible to a range of opportunistic infections and cancers. HIV can also infect nerve cells and cause brain damage. HIV is a retrovirus, i.e., its core consists of RNA. When this is injected into a human cell, an enzyme called reverse transcriptase converts the RNA into DNA, which is then inserted into the DNA of the human cell. Replication takes place when the infected cells are activated in fighting another disease. Although antibodies to HIV are produced by the body, they do not inactivate HIV.

The natural history of HIV infection can be divided into five stages, each with its own clinical manifestations. Current evidence suggests that about 20% of those infected with HIV may go on to develop full-blown AIDS within five years and about 50% within ten years. HIV can be transmitted from an HIV positive women to the foetus during pregnancy and birth, and sometimes to the newborn, from breast-feeding. Sexual intercourse is the most frequent mode of transmission of HIV; parenteral transmission also occurs through the transfusion of infected blood or the use of blood-contaminated skin-piercing instruments.

STDs refer to communicable, sexually transmitted diseases which have a direct relationship with HIV infection. STDs are an indicator of high risk sexual behaviour and increase the chances of HIV transmission particularly among those with genital ulcers. Thus, early and effective treatment of STDs becomes crucial in reducing the risk of HIV transmission.

BASIC INFORMATION ABOUT HIV/AIDS FOR COUNSELLORS

Counsellors must know the basic facts about HIV infection and its manifestations. Information regarding the causes and epidemiology of HIV infection, AIDS and related diseases is increasing rapidly and busy counsellors will be aware of the limits of their knowledge. This module aims at providing the essential facts about the infection and its implications based on present day knowledge.

While reading and thinking about this basic information, trainees should plan how they would talk about symptoms and infections to the people of their own state and to persons from a variety of cultural backgrounds and traditions. The San Francisco AIDS Foundation has explained the acronym AIDS in a way that may be helpful when talking to concerned or affected people, families and others.

AIDS stands for:

Acquired	-	not born with
Immune	-	body's defense system
Deficiency	-	not working properly
Syndrome	-	a group of signs & symptoms

As evident from its name, AIDS is not a single disease, but a syndrome - a cluster of symptoms which results from the destruction of the body's defenses by HIV-the Human Immunodeficiency Virus.

Every human being has an efficient body mechanism to protect it against disease. This mechanism is called the "Immune System". Unknown to us, the immune system is at work, recognizing foreign bodies (eg. bacteria, virus, micro organisms) and fighting them. It does this with an array of cells and by producing specific chemicals called antibodies which neutralize the foreign bodies. Each disease stimulates the production of antibodies specific to it. The detection of these antibodies is therefore used to determine past and present infection.

As HIV causes damage to the immune system itself, the antibodies detected in the blood of the HIV carrier are unable to fight the virus, which may be present in large numbers in the body. Therefore, the body cannot be protected against other infections and cancers, some which then become the direct causes of death. These infections are called **"opportunistic infections."**

THE NATURE OF THE VIRUS

The first cases of AIDS were recognized in the United States in 1981. The virus that causes it, now called HIV, was first isolated in 1983 at the Institute Pasteur in Paris. In India, HIV seropositivity was first recorded among 10 female prostitutes in Tamil Nadu in April 1986.

A new virus has recently been identified in West Africa, India and Srilanka. This virus, which is related to the virus first discovered acts in a similar way, with similar routes of transmission and is spreading to other parts of the world. The first AIDS virus is now called HIV-1 and the second, HIV-2.

HIV selectively infects specific white blood cells (CD4) that are an essential part of the body's immune system. When the CD4 cells are destroyed, the infected person becomes susceptible to a range of opportunistic infections, diseases and cancers and the group of such conditions is called AIDS. HIV may also directly infect nerve cells and cause neurological disorders. HIV infection is presumed to be lifelong and the infected person is likely to remain infectious for life.

Structure of HIV

HIV is a member of the retrovirus family of viruses which has been known to cause a number of different diseases in animals. Like all retroviruses, HIV contains RNA in its core; the virus itself is surrounded by a protein and lipid envelope or "coat".

To replicate itself in human cells, the virus first needs to select cells to which it can attach itself; these cells carry a special"receptor" known as the CD4 antigen. This receptor occurs on cells in the body's immune system, called the CD4 cells , and on some macrophages. There is some evidence that other cells can support the growth of HIV, such as those in the lining of the bowel (bowel epithelium) and in the brain (microglia cells).

Replication

When the virus has made contact with a CD4-antigen-carrying cell, it sheds its lipid coat and injects its RNA into the human cell. The single-stranded RNA then makes a copy of itself with the aid of an enzyme called reverse transcriptase. This yields double-stranded DNA, which then inserts itself into the DNA of the human cell. As HIV becomes part of the human cell's genetic material, infection of the cell is irreversible. Although it may be possible to develop a drug that suppresses the activity of the virus (thus keeping an infected person relatively healthy), there is no prospect of cure in the sense of eliminating the integrated viral DNA.

The viral DNA starts to instruct the human cell to produce viral components such as viral proteins and RNA - the two main components of HIV. The viral proteins migrate to the surface of the infected cell. Then, by a process known as budding, enormous numbers of new virus particles detach themselves from the infected host cell, and are taken away in the bloodstream to become attached to other cells carrying CD4 receptors.

The virus may remain dormant for months or even years. In the event of another infection, the infected cells get activated by the body's immune syotem and the HIV begins to make copies of itself that go on to infect more human cells.

Any other infectious disease, by activating the immune system, is therefore likely to lead to viral replication. However, there is some evidence that a few common viral infections such as those caused by herpes simplex virus and cytomegaloviral disease virus can specifically increase the replication of HIV. Increased replication of the virus means that an infected person is more likely to develop full-blown AIDS. This is because such replication leads to progressive destruction of infected cells, thus destroying the body's immune system and decreasing its ability to fight off infection from other diseases. The advice given to those who are infected with HIV- to lead a healthy life-style - therefore has a firm scientific basis. (see "Practical information for People with HIV Infection or Disease in Appendix I of this Manual").

If the infection is primarily in the brain, viral replication may cause it to deteriorate, which will often result in dementia associated with encephalopathy and possibly other opportunistic diseases.

Although the body's immune system does produce antibodies to the virus, they do not seem to be able to inactivate the virus. The virus in circulation therefore, is able to spread to other parts of the body and can be transmitted to sexual partners, and passed on to others through infected blood, blood products,and other body fluids (semen, vaginal/cervical secretions), and from an infected mother to her child before, during, or shortly after birth, and possibly also through breast milk.

Life of the virus

HIV, like other viruses, is easily destroyed by boiling and steaming (autoclaving). The virus can be destroyed by various chemicals used in standard disinfectants - hypochlorite, glutaraldehyde and formaldehyde, normally recommended for hepatitis B virus - as well as alcohols, acetone, phenol, household bleach 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.

STAGES OF HIV INFECTION

HIV Infection

HIV infection progresses through several stages. It begins when an individual becomes infected with the virus. HIV infection causes a progressive impairment of both the immune and nervous systems. Over time as this impairment worsens, it begins to show itself as symptoms. Subsequently there are various increasingly serious stages in the life cycle of HIV infection. The early, middle and late manifestations of HIV infection can therefore be classified. In addition, once infected, the person is infectious (i.e. able to transmit the virus to other people) for life.

Acute Seroconversion Illness

Within 3-8 weeks after infection, some (but not all) people develop an acute illness lasting 2-3 weeks with symptoms such as fever, rash, joint and muscle pain, swollen lymph glands, diarrhoea and sore throat. Symptoms may be mild which will eventually disappear completely. This self-limiting condition is known as an acute seroconversion illness. During this period the virus continues to reproduce itself inside the body and the person's immune system responds by developing antibodies to the virus.

Within 6-12 weeks after the infection, it is usually possible to detect HIV antibodies in the blood. Unlike antibodies to most other micro-organisms, these antibodies do not destroy the virus effectively. In some infected people, antibodies cannot be detected for 6 months or longer, yet they are infected and infectious.

> The 6-12 week phase between infection and seroconversion is called **"WINDOW PERIOD"**. At this time the person is already infected (as well as infectious) but the blood test will not indicate presence of HIV. This is because the blood test only indicates presence of antibodies and not HIV itself and formation of the antibodies takes 6-12 weeks.

Asymptomatic Infection

The person may remain asymptomatic and feel and appear healthy for years, even though he or she is infected with HIV. During this asymptomatic period, the person remains infectious (ie able to transmit virus to others via sexual, blood borne and perinatal transmission) and as the virus continues to replicate, it causes progressive damage to both the immune and nervous system. If his/her blood is tested during this stage, it will test positive for HIV antibodies. Some individuals will have persistently enlarged lymph nodes (persistent generalized lymphadenopathy or PGL) during the asymptomatic stage of HIV infection.

Early Symptomatic Illness

Many individuals eventually develop a variety of indicators of ill health due to HIV infection without developing opportunistic infections or secondary cancers. These constitutional symptoms and signs are sometimes referred to as the AIDS Related Complex (ARC). These symptoms include complaints such as oral thrush, diarrhoea, weight loss, low grade intermittent fevers, loss of energy etc. Various fungal diseases (eg. tinea infection) or viral diseases (eg shingles) may be seen and individuals feel chronically ill during this stage of HIV infection.

Late Symptomatic Illness i.e. AIDS

Eventually, individuals will have episodes of AIDS specific opportunistic diseases, such as Pneumocystic Carinii Pneumonia, encephalitis caused by Toxoplasma gondii and severe and chronic diarrhoea caused by cryptosporidia and microsporidia. Pulmonary tuberculosis is increasingly being recognised as one of the most common opportunistic diseases associated with HIV infection, especially in the developing world (eg. India). Opportunistic cancers, such as Kaposi Sarcoma and undifferentiated B Cell lymphomas may also be seen. In addition to the above, there will be significant weight loss and both neurological and neuropsychiatric syndromes may be present. This end stage of HIV infection is referred to as AIDS. Patients in this stage will eventually enter a terminal phase and die.

DIAGNOSING HIV

The early diagnoses of HIV infection is through blood testts. The most widely used blood test is the Enzyme Linked Immuno Sorbent Assay (ELISA) which detects the antibody generated in response to HIV infection. Another blood test called Western Blot is more expensive and is thus no longer recommended for routine testing. Spot tests are also currently being used.

It is essential to obtain the consent of all patients prior to being tested for HIV antibodies. The results of their test (and the fact that they were tested) must be kept absolutely confidential and the patient must have both pre-test and post-test counselling. (See Module 3) One single screening does not call for a positive diagnosis if the test is positive. The National AIDS Control Organisation (NACO) 1993 policy recommends that one initial testing, in case the person/sample is found positive. Then a specific test should be performed to ascertain the type of HIV antibody i.e. anti HIV 1 or anti HIV 2 or both. This is to be followed by an ELISA/Western Blot test. (Facilitators can write to NACO for policy updates).

History taking is vital in the diagnosis of HIV infection so as to determine possible risk behaviours or factors. This will be determined by knowledge of how HIV is transmitted locally.

WHO has listed a few signs that help in provisional diagnosis of AIDS for public health purpose. The presence of two major signs with one minor sign (with the presence of HIV antibodies) can be an indication of AIDS provided that other causes of depleted immunity, like malnutrition, etc. are ruled out.

The major and minor signs are listed below:

Major signs:

Weight loss greater than 10% of the body weight
Continue fever for a period greater than one month.
Chronic diarrhoea (for greater than one month)

Minor signs:

Persistent cough for a period longer than one month
General itching dermatitis (skin irritation)
Recurrent Herpes Zoster (Shingles)
Oropharyngeal Candidiasis (fungus infection in the mouth/throat)
Chronic progressive and disseminated Herpes Simplex Infection
General lymphadenopathy (Swelling of lymph glands)

Progression from infection to AIDS

Initially it was thought that only a small proportion (5-10%) of HIV-infected persons would ultimately develop AIDS. Today, there is evidence that about 20% of those infected may develop AIDs within five years of becoming infected and about 50% within ten years. An increasing proportion will probably go on to develop AIDS after ten years, as people with HIV infection show progressive damage to their immune system over time.

CURE / VACCINE FOR AIDS
So far there is no cure for AIDS and a vaccine of prevention of infection may be far away.

Neurological manifesations

Neurological abnormalities such as peripheral neuropathy and memory loss in people with HIV infection are being reported increasingly. In some patients, they may be the initial manifestations of HIV infection and are often atypical in their presentation. The most frequent neurological disorder is a sub acute encephalopathy characterized by progressive behavioural changes associated with dementia; it occurs in approximately 1/3rd of people with late stage HIV infection. Its onset is usually insidious, and cognitive dysfunction initially predominates. Common early signs include tremors, slowness and aphasia. The course is usually progressive toward severe dementia. Mutism, incontinence, loss of vision and paraplegia may develop in the terminal stage.

Other causes of neurological manifestations in people with HIV infection include cryptococcal meningitis, cerebral toxoplasmosis, lymphoma of the brain, papovavirus and cytomegalovirus disease.

Tuberculosis and HIV

One of the several opportunistic organisms that can attack people with HIV infection is Mycobacterium tuberculosis, the organism that causes tuberculosis (TB). Though this organism is present in the bodies of one-third of the world's population, it generally remains dormant in healthy individuals because of their healthy immune system. In people infected with HIV, it is quick to gain an upper hand over the damaged immune system and spreads to various parts of the body.

A parallel epidemic of TB following AIDS pandemic is already happening in many parts of the developing world. In South-East Asia, where TB exists as a latent infection in nearly 40% of the population, the deadly duo of HIV and TB mean an additional drain on the meagre health resources. Therefore effective treatment of TB is important.

TRANSMISSION OF HIV

HIV has been isolated from the body fluids of infected persons, including saliva and tears; however, only blood, semen, vaginal secretions, and breast milk have been implicated in transmission. Detailed epidemiological studies throughout the world have documented only three modes of transmission: sexual, parenteral, and perinatal.

Sexual Transmission

The virus can be transmitted from an infected person to his or her sex partner (man to woman, woman to man and man to man). During sexual intercourse (vaginal, anal and possibly oral), damage to the linings of sexual organs such as vagina or rectum can facilitate transmission of HIV from the infected partner to the uninfected one by exchange of body fluids. It is easier for the virus to be transmitted if the uninfected partner is already suffering from some sexually transmitted disease, because in this case the lining is already damaged. Due to the high rate of sexual transmission of this virus, sexual behaviour is the prime focus for interrupting transmission. In India, sexual intercourse is the most frequent mode of transmission of HIV.

Parenteral Transmission

Parenteral transmission occurs through the transfusion of infected blood or blood products, or the use of blood-contaminated needles, syringes, or other skin-piercing instruments. The risk of acquiring HIV infection is related to the size of the inoculum. Recipients of a single unit of HIV-infected blood have virtually a 100% probability of becoming infected.

Transmission through blood transfusion is a significant problem in areas where HIV infection is common and where HIV-antibody screening of blood donors has not yet been introduced. Transmission through HIV-contaminated needles and syringes is a particularly serious problem among injecting drug users, and where needles and syringes are not sterilized before reuse.

The risk of transmission in health care settings i.e. from doctors/nurses to patients or vice versa through needle pricks is very low - only 0.3% or 0%, if universal health precautions are taken (See Appendix II for more details on Universal Health Precautions).

Perinatal Transmission

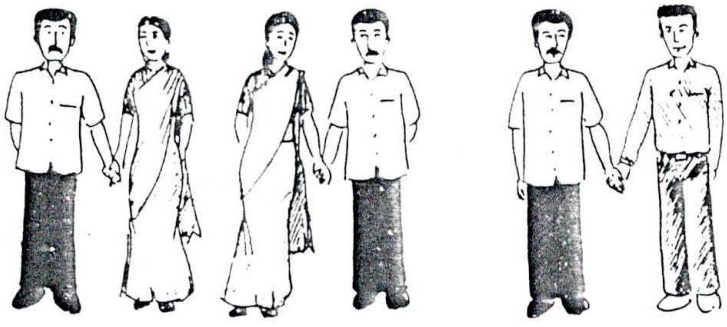
Transmission of HIV from an infected woman to her focus/infant may occur before, during and shortly after birth. The overall risk of HIV transmission from an HIV-infected woman to her focus or infant in utero or during delivery is 20-40%.

Postnatal transmission through breast milk has been observed in a small number of infants whose mothers acquired HIV infection after delivery. The breast milk of mothers infected with HIV contains small amounts of the virus. Researchers have found that one-third of babies born to HIV-infected women become infected. Although this occurs mainly during pregnancy or birth, and although a large majority of infants breast-fed by HIV-infected mothers do not become infected through milk, recent data confirms that some transmission may occur through breast feeding. The risk to the baby appears to be "substantial" if the mother herself becomes infected while breast-feeding, and lower if she was already infected at the time she gave birth.

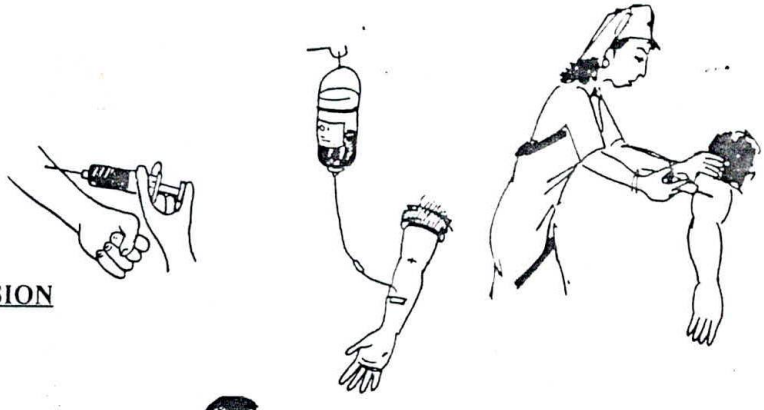
BREAST MILK IS STILL PROMOTED AS BREAST MILK OFFERS FAR MORE BENEFITS TO THE BABY, ESPECIALLY IN AREAS WHERE INFANT DEATHS ARE HIGH DUE TO INFECTIOUS DISEASES AND MALNUTRITION.

Where the primary causes of infant deaths are infectious diseases and malnutrition, infants who are not breast-fed run a particularly high risk of dying from these conditions. In these settings, breast-feeding should remain the standard advice to pregnant women, including those who are known to be HIV-infected, because their baby's risk of becoming infected through breast milk is likely to be lower than its risk of dying of other causes if deprived of breast-feeding. The higher a baby's risk of dying during infancy, the more protective breast-feeding is and the more important it is that the mother be advised to breast-feed. Women whose particular circumstances (economic, etc.) would make alternative feeding (formula milk) an appropriate option might wish to know their HIV status to help guide their decision about breast-feeding. In such cases, voluntary and confidential HIV testing accompanied in all cases by pre-test and post-test counselling could be made available. (For more details on breast feeding refer to Module 5).

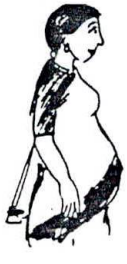
MODES OF HIV TRANSMISSION



SEXUAL TRANSMISSION



PARENTERAL TRANSMISSION



PERINATAL TRANSMISSION

In summary, the tables given on the following page show the importance of transmission of HIV infection through each route of transmission discussed above. It is evident from the table, that sexual transmission is the most common mode of transmission in Asia.

Note: Numbers are misleading. They are usually the reported number of cases and not actuals, therefore facilitators should use given statistics with caution. Facilitators must also make it a point to update their statistics.

BREAKUP OF SERO-POSITIVE CASES

Category	Sero-Positive	Percentage of Total
Heterosexual	6,402	42.63
Homosexual	41	0.27
Blood Donors	2,399	15.98
Dialysis pts	125	0.83
Antenatal women	68	0.45
Recipients of blood or blood products	296	1.97
Suspected ARC/AIDS	730	4.86
IV Drug Users	2,020	13.45
Others	2,936	19.56
Total	15,017	100.00

AIDS CASES IN INDIA
(upto 31st March, 1994)

Indian	Male	Female	Total
Indian	551	162	713

Source: AIDS in India, Newsletter of NACO, Dated June, 1994.

Non-transmission of HIV

The range of present attitudes towards AIDS is similar to the attitudes once seen towards syphilis in the early 19th Century. Myths and emotional hysteria can be generated due to misinformation about AIDS. Many myths about HIV today centre around the ways in which it can be transmitted. Extensive research has shown that there are only three well defined routes of HIV-transmission, as discussed above.

Studies show that **HIV Does Not Spread By:**

- Drinking water from the same glass as an infected person.
- Swimming in pools used by people with HIV or AIDS.
- Getting bitten by a mosquito that has already bitten an infected person.
- Getting bitten by an infected person.

- Socialising or casually living with people with HIV infection or AIDS.
- Caring and looking after people with HIV or AIDS.
- Use of the same toilets as AIDS patients or people infected with HIV.
- Shaking hands with people with AIDS or HIV infection.
- Hugging or kissing a person with HIV infection or AIDS.
- Casual contact such as sitting next to an infected person, or by coughing and sneezing, or from water, food, clothing, cups, glasses, plates, forks, spoons and other shared objects,
- Receiving and reviewing literature from areas of the world where there is AIDS.
- Donating blood.
- Bedbugs, flies, lice, fleas and other insects and pests DO NOT spread HIV.

MYTHS ABOUT HIV TRANSMISSION

(Source : Slides from Directorate of Health Services, Maharashtra)

PREVENTION OF HIV INFECTION

At present prevention is the only cure for AIDS. AIDS prevention and control has three main objectives: to prevent HIV infection, to reduce the personal and social impact of HIV infection; and to mobilize and unify national and international efforts against AIDS. **Prevention is indisputably the most important objective.** No curative drug or universally effective and affordable preventive vaccine is likely to be available in the foreseeable future. Since AIDS is essentially a sexually transmitted disease, sexual behaviour is the prime focus of action for interrupting transmission. It is therefore important to have an information and education programme aimed at all men and women, to have facilities for detection and treatment of other sexually transmitted diseases and to have an environment which would promote condom use and frank information dissemination without stigmatization and discrimination against people known or suspected to have HIV/AIDS. In India, prevention of **sexual transmission** is an immediate priority.

Safer sex activities for prevention via the sexual route include:

- abstinence,
- non-penetrative sexual activities e.g. hugging, kissing etc,
- mutual masturbation i.e. anything that does not involve sharing of semen, vaginal secretion or blood,
- long term mutually faithful relationship (the lesser the number of partners the lower the likelihood of getting infected), and
- proper and consistent use of condoms from start to finish for penetrative sex (vaginal, oral and anal).

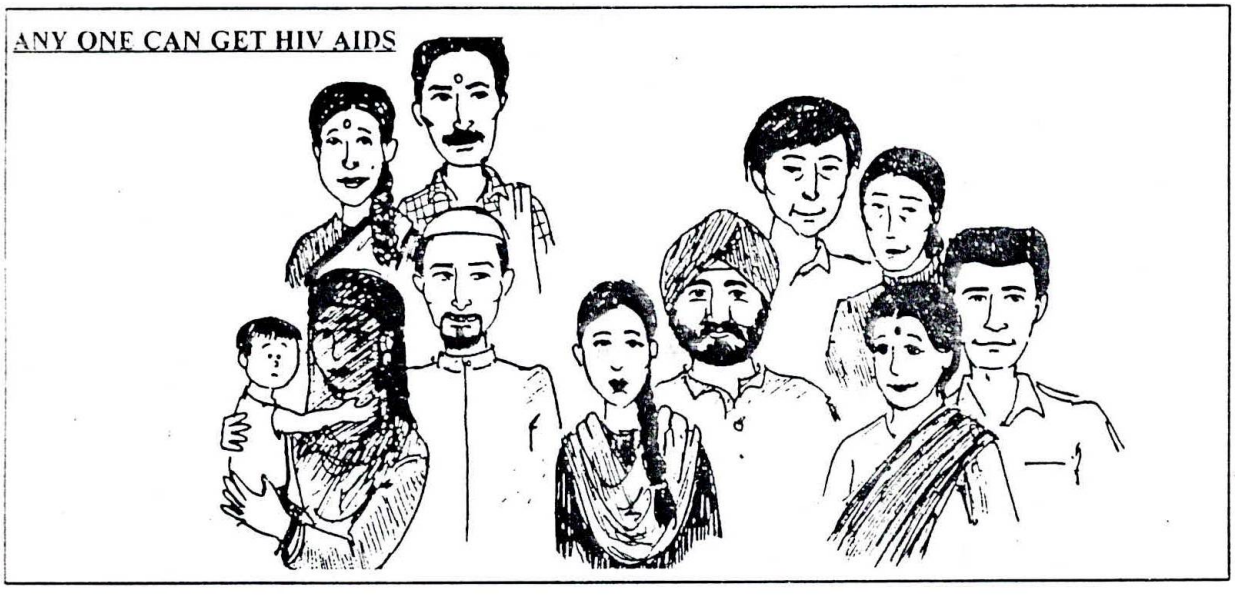
For prevention of HIV transmission through infected blood and blood products, the approaches that have proven effective include recruiting voluntary non-paid donors, screening all donated blood for HIV and educating health care workers to reduce unnecessary transfusions.

Preventing transmission at health care settings rests on careful attention to infection control procedures including proper sterilization of equipment, proper adherence to procedures based on "Universal Health Precautions", and provision of necessary supplies and equipment.

Preventing blood-borne transmission among drug injectors should go hand-in-hand with efforts to prevent sexual transmission among them. These should include reducing the demand for drugs, the use of drugs by injection, and the sharing of injection equipment.

It is possible to screen blood and blood products, through testing of all blood samples for HIV. However, this does not take into account blood screening done during the window period, where the person is already infected but his/her immune system has not produced antibodies against HIV. This would mean that the blood sample may or may not be free of HIV. In Bhutan, Indonesia and Thailand, all donated blood is now screened for HIV, while in other countries of the South-East Asia Region, the proportion of blood screened is on the increase.

Cost effective approaches in HIV testing are also being promoted, including testing of pooled sera, in populations where sero-prevalence of HIV is low. To avoid expensive tests, guidelines for alternative and cost effective testing techniques have been developed.



The best strategy **for preventing transmission from mother to child** is of course, to prevent the sexual transmission of HIV to women of reproductive age. Secondary prevention would depend on the avoidance of child-bearing by women who know or suspect that they are infected. Counselling and contraception services should be made available for all women.

WHO estimates that 16-17 million adults and children are infected with HIV in the world. Most of these will develop HIV related illness and ultimately AIDS. Therefore we need to plan for care of these patients at hospitals and at home. They must receive treatment for common opportunistic infections such as tuberculosis etc. In addition, infected individuals need understanding and compassion to enable them to maximize their health and human potential. As AIDS effects people in their most productive years, the economic impact on families with HIV-infected members is enormous, especially on children who may be orphaned. The impact of AIDS on society would include enormous health care costs, decimation of the work force and loss of skilled labour and educated professionals.

It is important, therefore, to recognize that AIDS is not just a health problem but it has major medical, social, and economic consequences. In India, the challenge of denial and complacency needs to be overcome in order that effective AIDS prevention programmes can be put in place with the highest level of political commitment. A broad-based, **multisectoral response** is urgently needed including the critical role that NGOs can play in promoting safer sex practices, providing support to people with HIV/AIDS and combatting complacency and stigmatization.

Key Interventions and Approaches at the national & state levels

Information, education and communication (IEC)

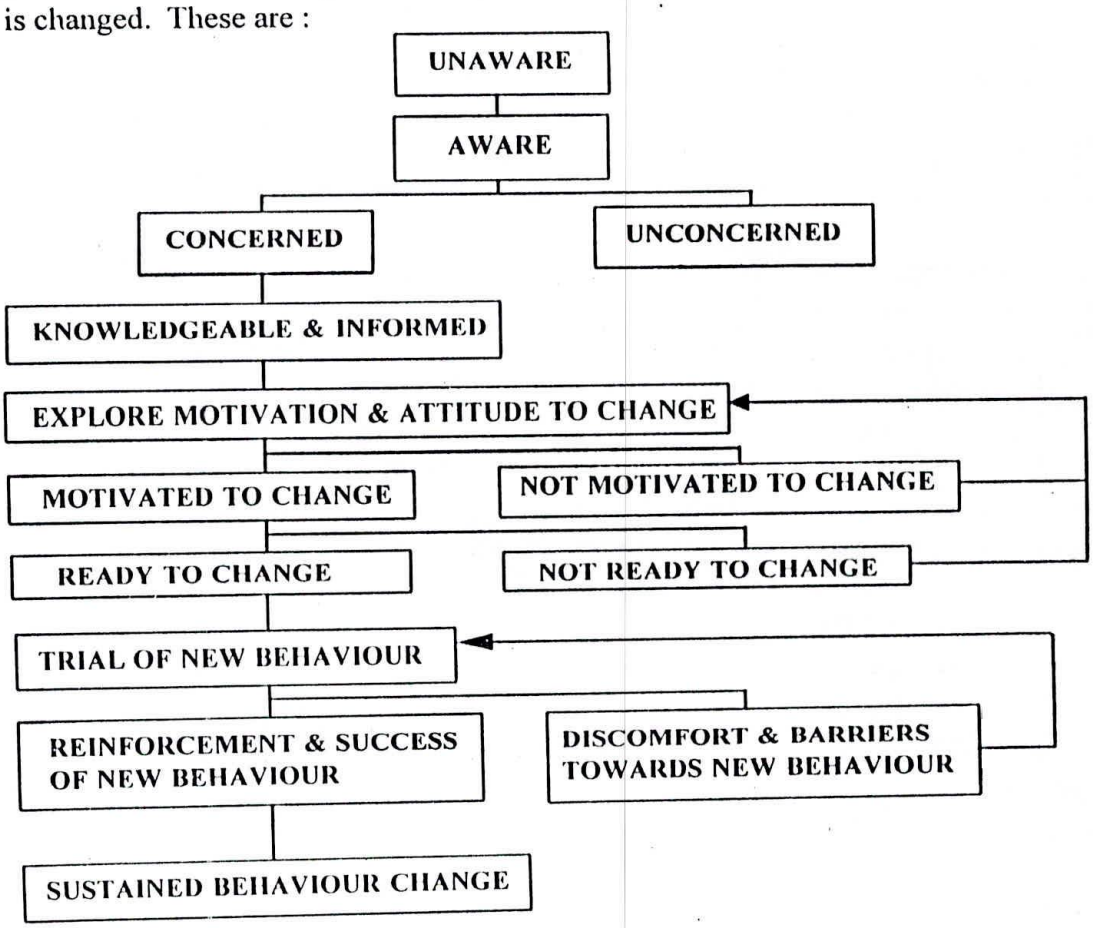
In the absence of a cure or a vaccine, health education or IEC remains the primary tool for combatting the HIV pandemic. However, knowledge about HIV transmission and AIDS is presently confined to a very few. Moreover, it is important to realize that knowledge does not necessarily lead to action in terms of behaviour (in case of HIV/AIDS it is highrisk behaviour) change. (More details on Risk assessment in Module 3).

In order for health education programmes to succeed, support services such as condom promotion and counselling services must be available. Social and behavioural research is necessary to assess the level of knowledge and to determine which channels of communication are more appropriate and effective.

The flow of behaviour change proceeds like this :

Information/Education → Attitude change → Behaviour change

While doing risk assessment, risk reduction or pre-test/post-test counselling the counsellor should keep in mind the natural stages the client's thinking and reactions will go through before behaviour is changed. These are :



Targeted Interventions Among Intravenous Drug Users

The prevention and control of HIV infection in intravenous drug users (IVDUs) can be a more daunting task due to the complex issues involved.

In all regions of the world, the first objective is to prevent drug abuse. In regions with very low rates of use of illicit drugs and absence of trafficking networks, prevention of the establishment of such a network through law enforcement is the first priority.

In other regions where drugs are widely used but rarely injected, namely most parts of India, the first priority in containing the spread of HIV infection in drug users, is to prevent a shift towards drug injecting. Public and mass media campaigns against injecting are probably counter productive in such a situation since they tend to raise curiosity rather than deter from the switch to injection in a group, which by the fact of being marginalized and criminalized, is unlikely to follow advice from authorities. There is already an example to prove this point. A rapid switch to drug injecting in Nepal followed a strong media campaign against injecting drug use. Only low key, peer-to-peer programmes are likely to be effective in such situations.

Injecting drug use is already widespread in some states in India, although initiation into drug use still occurs almost invariably by smoking/inhaling. In such situations, in addition to an abstinence-oriented treatment approach, a series of subtle harm reducing strategies are being promoted. These include oral opiate maintenance; peer-to-peer programmes for converting drug injectors into drug inhalers; and education for decontamination of needles and syringes with bleach (5 per cent sodium hypochlorite), especially for IVDUs in prisons. These measures should be combined with outreach programmes for those drug users who are still untouched by the existing systems of help. In regions where large droppers or syringes are used for injecting in groups, thereby considerably increasing the amount of blood exchanged, as in some northeastern states of India, substitution with smaller droppers and/or syringes should be an immediate priority.

Sexually transmitted disease (STD) management

Epidemiological data worldwide as well as in India shows that the major mode of HIV transmission is through sexual intercourse and that AIDS is primarily a sexually transmitted disease. The relationship between STD and AIDS is twofold; (1) STDs are a marker for high-risk behaviour; the same high-risk behaviour predisposing for STD, predisposes also for HIV infection, namely unprotected sexual intercourse with multiple partners; and (2) STDs appear to serve as an important risk factor facilitating the transmission and acquisition of HIV infection. Thus control of STDs contributes significantly to a reduction in HIV transmission and are an important component of AIDS prevention and control programmes.

SEXUALLY TRANSMITTED DISEASES (STDs)

STDs are Sexually Transmitted Diseases. Earlier, STDs used to be called veneral diseases. STDs are communicable diseases which are transmitted by an infected man/woman to his/her partner during sexual intercourse. For this reason, they are called Sexually Transmitted Diseases. They are relatively easy to contract. STDs are serious and painful. Gonorrhea, herpes, chlamydia, syphilis and AIDs are the most common STDs.

A person becomes infected with STDs when he/she has:

- vaginal sexual intercourse, or
- anal sexual intercourse, or
- oral sex with an infected person.

The vagina, penis, rectum and mouth are the sources from which the STD germs can invade the body.

STD Symptoms

Many STDs show early symptoms which disappear without treatment. But the germs remain in the body, causing damage to different organs. Some STDs give mild or no symptoms at all, particularly in women. Anyone with an STD may look and feel healthy, but can still infect partners or unborn babies.

SOME SYMPTOMS OF STDs

WOMEN

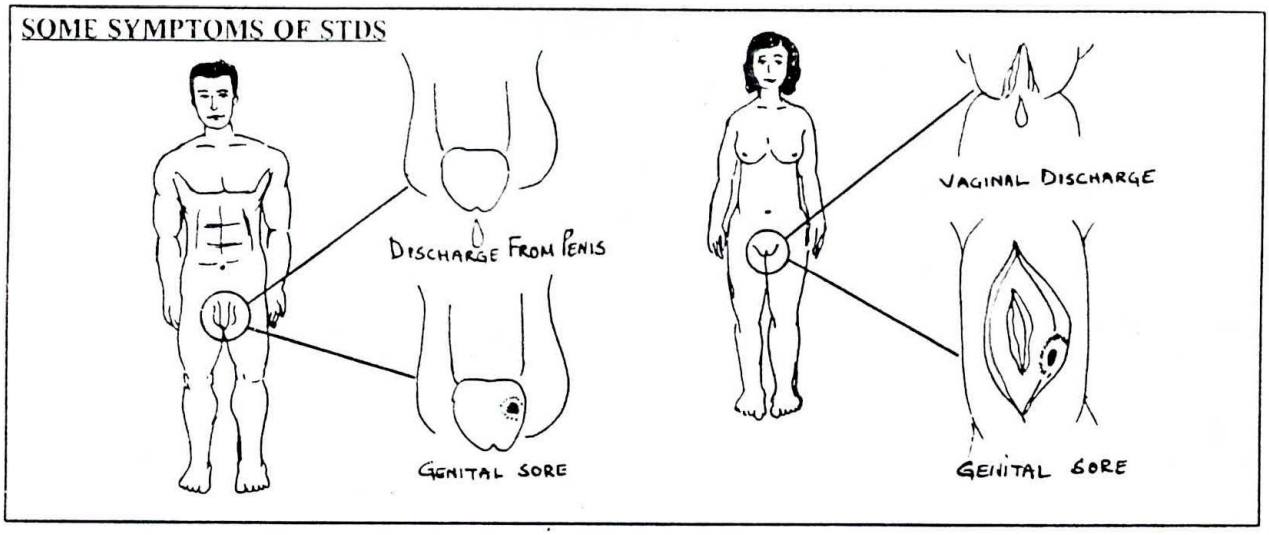
- Unusual discharge or foul smell from the vagina
- Pain in the lower abdomen - between the navel and sex organs.
- Burning or itching around the vagina.
- When having sex, pain deep in the vagina.

BOTH MEN & WOMEN

- Sores, lumps, blisters or rashes in or near the sex organs or mouth.
- Burning pain while passing urine or having a bowel movement.
- Fever, chills and aches - like flu.
- Unusual swelling and itching of and around pubic area.

MEN

- Discharge from the penis.



In the absence of proper treatment, there may be various complications due to STDs. They include:

- Complications of pregnancy - congenital syphilis leading to still birth. Other STD infections may be responsible for other birth defects.
- Complications in infants - infection with gonorrhoea causing blindness, other complications are conjunctivitis (an eye infection) and pneumonia.
- Complications in others - infertility, hepatitis, dementia and cancer.
- Sterility.

Some of the Misconceptions prevalent in India regarding STDs

Regarding STD transmission:

- Lack of genital hygiene for eg. visiting a dirty urinal, using a dirty sanitary pad, dirty underwear, or an infected condom (which itself suggests the reuse of condoms) causes STDs.
- Excessive heat eg. through spicy food and alcohol or through constitutional or occupational reasons leads to STDs.
- Non-sexual contact with an infected person, eg. touch, sharing objects, urinating at the same place as an infected person causes STDs.

Regarding STD prevention:

- The only way to prevent STDs is seen as avoiding CSWs or washing genitals with own urine, water, soda and lime juice.

Regarding STD treatment:

- Home remedies are believed to be adequate for STD treatment. STDs are viewed as curable but there is poor awareness about places of treatment.
- Sex with a donkey, a child, or with a virgin of the opposite sex is said to cure STD.

Regarding STD disease:

- During infectious stage, it is believed that the urge to have sex and pleasure sex is high for both sex partners (a particularly dangerous belief).

Prevention and Treatment of STDs

Abstinence is a fool-proof method of preventing STDs, but a really difficult one. The following guidelines can do much to prevent STDs:

- Avoid sex with partners who have genital rashes, redness, sores or discharges.
- Stay away from casual relationships.
- Reduce the number of your partners as much as possible.
- Use condoms.
- Urinate and wash the genital area after intercourse. This helps in avoiding some genital infections.
- Prevention of STDs would also reduce the risk of HIV transmission.
- Treatment should not be stopped when symptoms disappear, but continued till blood (VDRL) test reports are negative.

Early treatment is always desirable to prevent complications and further spread of infection. Upon suspicion of infection, the person needs to consult a health clinic or the family physician. Regular check-ups are also recommended if, safe sex is not practiced, or, as soon as any sign of an STD is noticed. Most STDs can be cured if correct treatment is given but HIV/ AIDS cannot be cured. It should be remembered that early diagnosis and treatment of STDs would reduce risk of HIV transmission.

IMPLICATIONS OF HIV/AIDS IN INDIA

We have already seen how HIV infection occurs and how this can lead to AIDS. Being a fatal infection for which neither treatment or vaccines are available, AIDS, if unchecked, is likely to cause a significant influence on various aspects of daily life. It can have a serious impact on the demographic economic and social structure of our country in an unplanned and precipitative manner which would offset a lot of the progress made over the years.

1. Demographic Changes

The population most at risk and affected is the sexually active, which means the age group between about 15 and 40 years. A disproportionately large number of AIDS related deaths in this age segment would lead to :

a. **Changes in the age structure of the population**
Most studies in India and abroad show that the maximum number of HIV infected individuals are in the 20 to 30 age group. This would mean that a disproportionate number of those aged 30 to 40 years are likely to die. This will of course skew the age structure of the population and lead to further effects.

b. **Increase in the number of dependents (elders & children).**
This is often the age when people have young children and dependent elders at home.

c. **Increase in the number of orphans.**
The Indian society has traditionally coped with orphans by having them cared for by their uncles and aunts. Here it is also likely that most uncles and aunts would also be affected or would be already overburdened by caring for others.

d. **Reduction in the productive work force.**
This age group of people are at the peak of their productive life. As most HIV infected individuals in this age group are likely to die, there would be a large reduction of the number of people available to work.

2. **Economic Impact**

The economic impact of AIDS can be considered in terms of its direct influences on the economy as well as the indirect effects it can have. With increase in sickness and reduction in work force, there is likely to be:

a. **Reduced availability of manpower.**

b. **Reduced productivity in the country.**
This reduction will involve people who are trained in various specialised skills and jobs. The loss of investment in training along with the decreased availability of personnel will have a direct impact on productivity. The effect of this will be obvious in the organised sector like the industry, army etc as well as in the un-organised sector like agriculture.

c. **Loss of income to the family.**
The death of the wage earner will lead to a loss of income for the family. Further, there would have been other unanticipated expenses like costs for care, medicines, funeral, etc.

d. **Increase in poverty.**
Increased costs to the family leading to increase in poverty. Besides this many more families will slip into lower economic levels or even below the poverty line.

e. **Increased spending on health care.**
The overall impact of AIDS in the country will also mean a higher allocation of resources towards health to cope with the needs of the community.

f. **Diversion of resources from other priority areas.**

g. **Negative impact on development.**
These factors automatically follow and may slow down or increase the progress made by the nation in various areas.

3. **Health factors**

a. Increased infectious diseases and Increase in general morbidity.
b. Breakdown of National Control Programmes (increased prevalence and loss of objectives. Negating gains made in health programmes eg. as in the case of tuberculosis).
c. Pressure on the health care systems to deal with the direct and indirect effects of HIV/ AIDS.
d. Increase in mental health problems both as a direct effect of HIV with dementia and encephalopathic syndromes as well as the increase in the overall stress related problems in society.
e. Increase in child and adult mortality rates.
f. Reduction in overall life expectancy.

4. **Social Effects**

a. Ostracising the individual, family & communities from lack of awareness. A general fear of AIDS as an unknown phenomenon easily ends up with society condemning those already infected. This could extend to the families of those infected, and also to marginalisation of certain groups, as those indulging in high risk behaviour. By marginalising and isolating those infected or at risk of infection, it would practically drive such people underground, thus making effective health education and prevention all the more difficult.

b. Loss of employment or reduced productivity in key members of a family will lead to significant economic and social losses. Loss of esteem and of social support networks could lead to significant hardships that a family will have to face.

c. Change in the traditional family structure as a result of ill health and death can lead to the break up of the traditional family roles. This will have its impact on family dynamics in many areas.
    i) Relationships: Marital and other intra-familial relationships are significantly stressed with the onset of HIV infection in one of its members.
    ii) Supports: the family network as it exists today probably offers the most important means of emotional and other support to its members in our society. Changed family dynamics are likely to put this support system to significant strain and reduce its efficacy.

iii) Norms, values and role models: when children grow up without parents or with single parents, difficulties in identifying with social roles can occur. Additionally, when economically and socially deprived, norms and values learnt within a family could get deficient. These factors have secondary effects like deficient personality development, delinquency, increasing cases of school drop outs etc.

d. Increased burden on family resources, or elders/children and in health care costs will result in gradual increased burden on women, elders and unrelated adults.
e. Change in family structure/functions and roles lead to increased responsibilities and burden on the community's resources.

f. Increased dependence on the formal sector for social support. This is already rudimentary and unlikely to be able to cope with additional demands made on it. Non-formal organised sectors like Non Governmental Organisations (NGOs) will be looked on as resources and need to be strengthened.

g. An increase in other social phenomenon like migration, urbanisation, poverty, crime and suicides can be envisaged.

Role of Counselling and Health Education

Counselling complements health education but serves a different purpose for the many people who may not believe that they themselves are directly threatened, who find it hard to change risk behaviour, or who are unable to apply general information to their own specific circumstances. Counselling is essential in helping such people to:

1. Understand the consequences for themselves and others of their risk behaviour.
2. Define their potential for changing risk behaviour to protect both their own health and the well being of others; and
3. Find and use the personal and social resources necessary for starting and maintaining behavioural change or managing illness.

Education is an important tool for counsellors. A counsellor teaches constantly, giving new information, separating fact from myth and informing clients about available resources. The counsellor both guides and educates, whether in helping a client determine how to avoid infection, deciding whether or not to take a test, or explaining how HIV infection is transmitted. Counselling is therefore, geared to motivating people to interpret information, incorporate it, and act on it. The aim is towards helping people cope with their stress and fears regarding their potential or actual infection with HIV.

Health education and counselling aim at changing risk behaviours; and use two way interaction and rely on communication skills. However, beyond just education, which is emotionally neutral, counselling involves strong emotional overtones. The role of the counsellor then becomes to augment the coping capacity of the individual and family to deal with the emotional impact of HIV infection.

Counsellors must keep up with current knowledge and combine this knowledge with their skills in listening, supporting and guiding.

Suggested Readings

Gordon. G., & Klouda. T. (1988) : Talking AIDS. IPPF, London.

Mann. J., Tarantola. D.J.M., & Netter. T. W. (1993): A global report, AIDS in the world.

Pavri. K. (1992): Challenge of AIDS. New Delhi : National Book Trust of India.

ACTIVITY 1: Introduction

Time: 15 minutes

Objective:

Trainees are able to familiarise with the workshop objectives and schedule and should be able to verbalise their expectations from the workshop.

Procedure:

The trainer uses this time to introduce himself/herself and the other facilitators. He/she welcomes the trainees and guests (an icebreaker can be used). Trainees are made familiar with the objectives of the programme and of the schedule. Their expectations are noted.

ACTIVITY 2: Quiz

Time: 20 minutes

Objective:

Trainer becomes aware of the level of knowledge and the attitude of the trainees regarding HIV/AIDS.

Procedure:

Ask the trainees to complete the quiz given in **Worksheet 1** by themselves. As they complete the quiz, ask them to keep the paper with themselves for later use.

WORK SHEET 1

Quiz

SECTION:1

ARE THE FOLLOWING STATEMENTS CORRECT OR INCORRECT (write "Correct" or "Incorrect" next to each sentence) :

1. People who have multiple sexual partners are responsible for AIDS.
2. You cannot get AIDS by casual contact.
3. AIDS is spread through insect bites.
4. Donated blood is being tested for AIDS.
5. Some traditional healers can cure AIDS.
6. Once a person is infected, blood testing will always indicate positivity.
7. HIV attacks CD4 lymphocytes only.
8. Blood donation will give you AIDS.
9. HIV infection will eventually develop into AIDS.
10. Condoms are 100% effective against HIV transmission.
11. The pregnant mother to foetus transmission rate of HIV infection is 89-100%.
12. Once a person is infected with HIV, his life is over.
13. There is nothing that can be done for a person with AIDS.
14. One can generally identify a person with HIV infection by looking at him/her.
15. Anyone who has unprotected sexual intercourse with multiple partners is at risk of HIV infection.
16. A pregnant woman infected with HIV might pass the infection to her unborn child.
17. Condoms when properly used, can help protect you from HIV.
18. AIDS can be cured if detected early
19. Should condoms be encouraged in regions, where there are few reported cases of HIV infection?
20. Breast feeding in developing countries should be encouraged regardless of the HIV status of the mother.

SECTION:2

TO ANSWER THE QUESTIONS, CIRCLE THE RESPONSE YOU THINK IS MOST CORRECT OR FILL IN THE BLANKS.

1. What is the full form for AIDS and HIV?
   AIDS _____
   HIV _____

2. The primary modes of transmission of HIV are:
   a _____
   b. _____
   c. _____

3. In which of the following ways is, HIV transmitted?
   a. Having unprotected sexual intercourse with an infect partner
   b. Donating blood
   c. Using public toilets

4. You can get HIV from:
   a. Mosquito bites
   b. Sharing food
   c. Hugging someone with AIDS
   d. Mosquito bites, sharing food and from
   e. None of the above

5. For which of the following purposes do people share needles?
   a. Tattooing
   b. Steroid injections
   c. Injecting drugs
   d. Ear piercing
   e. All of the above

ANSWERS TO SECTION:1

1. incorrect
2. correct
3. incorrect
4. incorrect- because donated blood is being tested for presence of HIV Antibody; the individual's Response to HIV infection.
5. incorrect
6. incorrect- because of the window period 6 to 12 weeks
7. incorrect
8. incorrect
9. correct- eventually develops into AIDS
10. incorrect- 95% safe
11. incorrect
12. incorrect
13. incorrect
14. incorrect
15. correct
16. correct
17. correct
18. incorrect
19. correct
20. correct

ANSWERS TO SECTION:2

1. Acquired Immuno Deficiency Syndrome; Human Immunodeficiency Virus
2. Sexual; parenteral; perinatal
3. a
4. e
5. e

(The Quiz has been adapted from HIV/AIDS Counselling Training Manual AIDS Control Programme. Ministry of Health. Malawi and from WHO-SEARO (1993), An Orientation to HIV/ AIDS Counselling - A Guide for Trainers.)

ACTIVITY 3: Presentation

Time: 2 hours

Objective:

The purpose of this activity is for the trainees to get a basic understanding of HIV/AIDS, and its relationship with STDs.

Procedure:

The trainer uses this time to do a presentation on HIV/AIDS information. The trainer should cover basic information, including transmission and prevention of HIV infection and its co-relation with STDs. The trainer could use audio-visual aids like slides, OHP material, video films, etc. during his presentation. The trainer could also invite an expert in this field for a guest talk.

ACTIVITY 4: Ranking Exercise

Time: 30 minutes

Objective:

Trainees should be able to identify high risk behaviours in relation to HIV/AIDS.

Procedure:

Ask the trainees to complete the "rank the risk" exercise(**worksheet 2**). They may rank from 1-10 (1 having the highest risk of getting AIDS and 10 having the least). Ask them to compare the answers and brain storm. Please note that there are no wrong answers. It is the risk behaviour which is to be highlighted, therefore the facilitators should focus discussion on high risk behaviours.

WORK SHEET 2

Ranking of Risk Behaviour

Who of the following has the greatest or least risk of contracting HIV?

Instruction: Rank form 1-10 (1 means having the highest risk of getting HIV and 10 means having the lowest risk for getting HIV). The same rank can be given to more than one person listed below. Please remember that it is not what you are but what you do that puts you at risk of getting HIV infection.

- ☐ School student with a classmate who has AIDS
- ☐ Medical doctor
- ☐ Family member of a person with AIDS
- ☐ Someone with multiple sex partners
- ☐ Traditional healer
- ☐ The unborn child of an infected mother
- ☐ Nurse
- ☐ Sex worker
- ☐ Voluntary blood donor
- ☐ Intravenous drug use
- ☐ Person with STD

ACTIVITY 5: **Role play on giving HIV/AIDS information**

Time: 30 minutes

Objective:

This activity helps in summarising the basic information regards HIV/AIDS.

Procedure:

Instead of the trainer summarising for the trainees, select 6 volunteers (3 pairs) from the group. One person plays the counsellor and the other the client. The counsellor explains one of the three areas of information given below to the client. The client may ask questions as often as necessary. Other group members observe and comment critically.

a) basic information about HIV (first pair)
b) modes of transmission (second pair)
c) methods of prevention (third pair)

ACTIVITY 6: Review Questions

Time: 20 mins.

Allow 10 minutes to the trainees to fill **worksheet 3**. Trainer to discuss the likely answers with the trainees.

WORK SHEET 3

Review Questions

1. What are the stages of development of HIV infection and disease?

2. How is HIV infection transmitted?

3. How can HIV infection be prevented?

4. What are the differences between STDs and HIV/AIDS?

MODULE 2
VALUES, ATTITUDES AND CULTURAL ISSUES

EXPECTED OUTCOME

On completion of this module, the trainee should be able to identify the psychosocial factors that affect people with HIV infection and be aware of their role in relation to social values, attitudes and culture and the need to be non-judgmental. The trainee will also be able to identify cultural issues associated with HIV/AIDS transmission and prevention.

MODULE AT A GLANCE
TOTAL TIME - 3 HRS 25 MINS

CONTENT SECTION

COUNSELLOR VALUES & ATTITUDES
CULTURE & TRADITION
PREVAILING SOCIAL POLITICAL & HEALTH RELATED ATTITUDES
MARGINALISED GROUPS

ACTIVITY SECTION

DISCUSSION IN PAIRS	:	50 mins
CONTENT PRESENTATION	:	1 hr
EXERCISE	:	15 mins
CASE DISCUSSION	:	1 hr
REVIEW QUESTIONS	:	20 mins

OVERVIEW

People from different backgrounds have different values, which influence their attitudes towards HIV infection and AIDS. Counsellors also have their own values and share their culture's prejudices, but must not allow them to influence their counselling. Therefore, they need to examine and become aware of their internal values, biases and culturally determined attitudes. Culture and tradition influence the way in which people respond to HIV infection and AIDS, and counsellors should respect the cultural influences of others. They therefore must explore the prevailing beliefs about illness and, in particular, HIV infection, and their efforts to motivate behavioural change must take these belief systems into account. They should help clients and their families to discover culturally acceptable ways of expressing emotions such as anger, guilt, fear or sadness. As HIV infection is transmitted sexually, cultural attitudes towards sex and sexuality are extremely important in advocating prevention; it may be difficult to change culturally sanctioned behaviour and therefore becomes necessary to find other more viable ways of protection.

COUNSELLOR VALUES AND ATTITUDES

People are influenced by the culture within which they live, develop and mature. Every culture has certain kinds of behaviour, ceremonies, rites of passage and points of view that are preferred above all others. These are called values. Some values are practically universal, for example - preserving the lives of innocent people, - but the values which guide and direct day-to-day behaviour are usually specific to the culture in which they evolve.

An HIV AIDS counsellor must understand and accept that people from different backgrounds have different values, and that these values influence attitudes towards HIV infection or AIDS. Values determine the degree to which a person asks for help, or attempts to handle a problem alone. They also determine how people view health, illness, and death.

Counsellors will have their own values, attitudes and beliefs but have to work with clients who may have values that are quite different. Fear and prejudice against people with AIDS causes stigma, discrimination, hostility and oppression, and may even be stronger than the values which underlie the humane care of the sick. Counsellors themselves may share their culture's prejudices, and must therefore examine and recognize their own prejudices and values. Competent counsellors do not have to like all their clients, but should be keenly aware of their own feelings, opinions, attitudes and prejudices. They must learn to recognise when they are not communicating clearly, or are distracted by the background or appearance of their clients, or are being influenced by bias rather than facts.

Counsellors must never allow their own personal values or prejudices to influence their counselling. If a serious conflict seems likely, the client should, if possible, be transferred to another counsellor. If this is not possible, the counsellor should consult a supervisor or colleague for help in resolving the difficulty. Some institutions may benefit from developing and operating a formal policy of reducing or eliminating prejudice or discrimination. Such a policy can be implemented with the help of staff training at all levels, supervision or staff support groups.

Counsellors must explore and reflect on their own feelings and prejudices which can interfere with the objective assessment of clients or, in the case of unremitting work with distressed and dying clients, the counsellor can have severe depression and may be unable to relate to other people. They will also need to decide how ready they themselves are to discuss sensitive topics and to what extent their own inhibitions and attitudes will complicate the task.

The kinds of questions which counsellors might ask themselves are:

- What are my own feelings about people whose behaviour has placed them at risk of infection?
- About people with HIV infection or AIDS? Am I afraid, critical, overwhelmed?
- In view of the ways in which the infection is sometimes contracted, can I treat certain persons as fellow humans, or will I see them as being at fault and immoral?
- Which sexual practices would be most difficult to talk about, given my own personal and cultural values?

- What everyday slang words would I use, or never use, to explain risk practices or behaviour, especially to clients who differ from me culturally or sexually, or are much younger or older?
- Can I maintain my own values of individual worth and dignity for everyone, even if my client's cultural background and way of life are very different from mine?
- How would I explain the need to discuss behaviour that is seen as strange or deviant in a particular society or culture?
- In this culture, to what extent am I ready to let clients do what they decide to do and take responsibility for their own care? Will I involve others in decisions if it is the accepted thing to do, or always try to be in control?
- How much do I want to influence, control or dominate other people?
- Are there some kinds of people or types of behaviour of which I disapprove so strongly that I probably could not counsel those concerned competently?

CULTURE AND TRADITION

Persuading people that they should change their behaviour and motivating them to do so are major counselling tasks. They will do so, or even consider doing so, only 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. Through culture, people learn acceptable behaviour, what is right and wrong. It determines or influences social status and the use of language. Culture is a product of the interaction of people, ideas and the physical environment.

Human beings interpret the world and their place in it according to their culture. It determines their 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 at times of transition (puberty or marriage rituals) or stress (illness or death).

Culture and tradition therefore influence how people interpret, explain, and respond to HIV infection and AIDS. Counsellors must examine their own beliefs, so as to be able to listen without prejudice and without censure to people from different backgrounds and cultures. They must first and foremost learn about, and respect, the culture and traditions of others, and not forget that particular culture.

The Culturally - Sensitive Counsellor

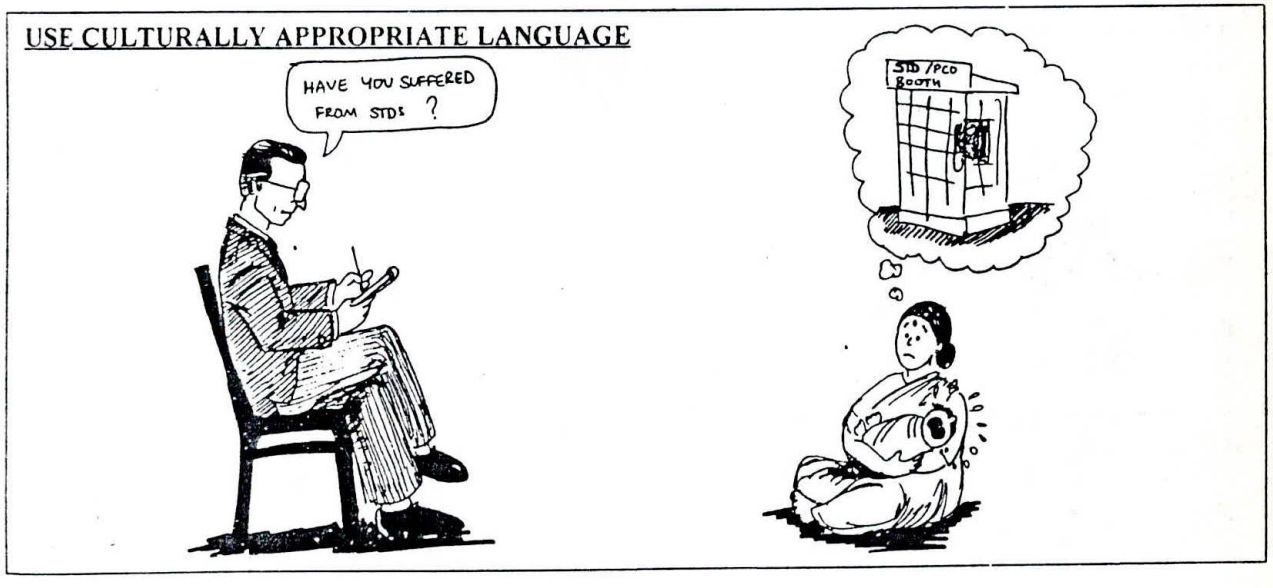
A counsellor may sometimes unknowingly behave or speak in ways which a client from another culture interprets as unusual, rude or even threatening. The client may then become silent and seem to withdraw from the session. When this occurs, the counsellor should comment on it, encourage an explanation, and change or adapt the counselling method.

It is largely in the use of words, or language, that counselling is adapted to culture. Language both expresses and shapes thought. Communication can take the form of speech (verbal) or of body language (non-verbal). These methods of communication are influenced by culture, which determines the form that they take and how they are accepted.

The counsellor should acknowledge differences so that they do not hinder or block the development of the counselling relationship. The counsellor must be sufficiently secure to admit unfamiliarity with a client's culture and to know how to question the client in order to decide how to conform to the client's cultural norms.

Cultural Attitudes towards Health

There are various factors that affect people's attitudes towards healthillness and health services and their perception and acceptance of the services. In a Bombay based study it is seen that slum dwellers are well informed about diseases and their treatment, but not about the need for early intervention to keep a problem in check nor about follow up and prolonged care to prevent relapse. It is also seen that women's health is traditionally neglected. It has been found that different types of illnesses are referred to different categories of the health system for example: sex-related problems are referred to traditional system of medicine. A HIV positive person or an AIDS affected person may fall into this category.



Cultural factors that affect the Health of the Community

Certain customs and practices, beliefs, values and religious taboos create an environment that helps in both the spread and the control of certain diseases and the promotion and maintenance of health. Illness or loss of health is attributed to more than one cause and hence the treatment taken varies. The perceived causes of illness or ill health are often of two types, supernatural causes and physical causes. Under the category of supernatural causes various categories of causes can be included like Breach of Taboos, Wrath of Gods and Goddesses, Sorcery, Evil eye and Ghost Intrusion. Diseases such as leprosy and sexually transmitted diseases are believed to be the result of certain taboo behaviour.

Diseases or ill health are attributed to physical causes which include excessive heat or cold, wrong combination of food and impurity of blood. As per studies STDs are often attributed to excessive heat, the treatment of which is generally in terms of intake of cold products.

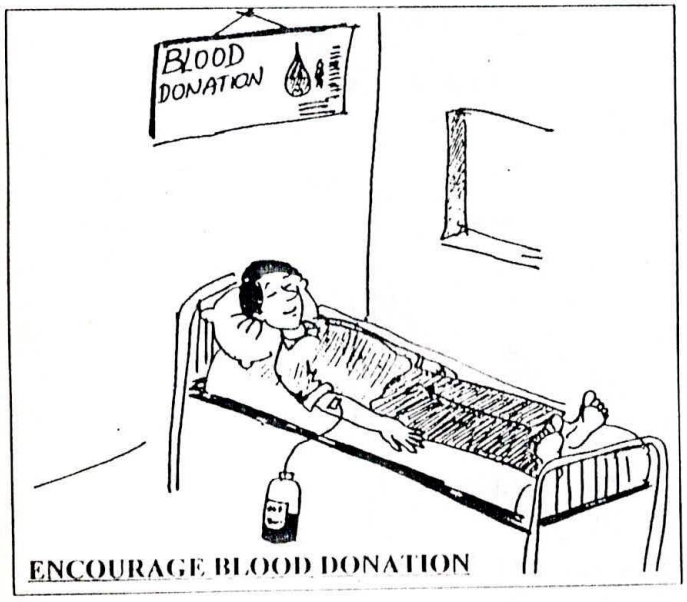
In the case of HIV/AIDS, infection may be viewed as being caused by supernatural factors and treatment may be approached from that angle especially for example; in the case of repeated and unexplained fevers and diarrhoea. Beliefs related to food intake and impurity of blood may also affect people's approach to prevention, diagnosis and clinical services in relation to AIDS. These need to be addressed in educational programmes in relation to HIV/AIDS.

Cultural Beliefs and Practices that affect the spread of HIV

1. Skin piercing

Specific beliefs and practices in relation to health are likely to have a closer bearing on behaviour that increases vulnerability to AIDS. They may pose as barriers against AIDS prevention and control activities. Skin piercing practices fall within this category. In India acceptance of the injection and skin piercing in general is almost universal except for immunisation in some regions. Prescriptions of injections are sought after as they are viewed to possess magical qualities. This faith in skin-piercing is often abused by healers who even give injections of distilled water to the ignorant. While these may have a placebo affect on people, the trend is not to be encouraged.

Skin piercing for decorative and ritualistic purposes (for example; ear piercing, tattooing, ear cleaning etc.) is also common among the rural areas, particularly among women and tribals. Studies need to examine the possibility of transmission of HIV.

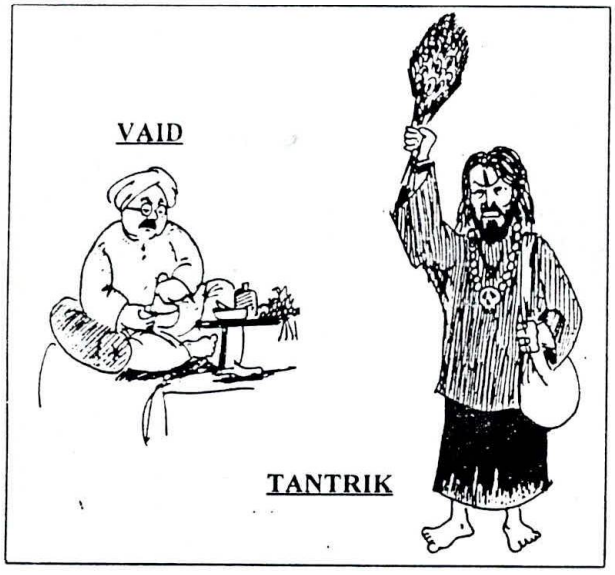


2. Blood:

The quantity and quality of blood in the body are viewed as significant by the general population to determine health. status. Stemming from this belief is the fear of loss of blood and of the belief of the quantity of blood as related to body size and health. Reluctance to donate blood and paranoia regarding "spoilt" or "defective' blood are a natural consequence. Blood Donation has thus been projected as the ultimate sacrifice in popular media (as Indian films) as it involves giving a part of one's sustaining fluid to another out of sense of sacrifice or duty. Blood Donation is however, not popular in India. Beliefs related to the loss of blood as damaging to health are firmly entrenched and resistance to "losing" blood is strong.

3. Cultural Attitudes Towards Traditional Healers

The role of health care providers belonging to alternative systems of medicine as well as traditional healers and quacks who are popular in India needs to be examined in the context of their contribution to health care, especially in relation to AIDS. The major Indian systems other than allopathy are ayurveda, homeopathy, unani and siddha. However, ayurveda and unani are the most significant in India and account for 75% of the total demand for consultation within the population according to studies. Many practitioners covered in a study reported dealing with cases of vaginal bleeding, anaemia, skin infections, sexual problems and respiratory tract infections. Thus their value in AIDS prevention and management cannot be under-emphasised and needs to be viewed seriously.



Despite the advancement of medical science, or high level of education, quacks flourish in any society, more so in societies like in India where rationality or high level of education is not always the rule. Certain alternative medicine practitioners sometimes referred to as quacks seem to enjoy a certain degree of popularity especially due to claims for reviving sexual potency and rejuvenating the old and the "weak".
The following characteristics explain to some extent the reasons for their popularity in treating such problems:

1. They claim possession of some formulae for preparing remedies believed to be efficacious in the treatment of certain diseases.
2. They claim that they possess certain cures for diseases for which modern medicines are inadequate.
3. They are able to publicise their successful cures through "word of mouth", testimoniáls by previous successful users and advertisements.
4. They tend to exaggerate the "services" motive though they are obviously profit oriented.

In view of these factors, health seeking behaviour in India is likely to lean towards these groups.

Studies need to be conducted so as to examine the claims made by traditional healers.
When no other medical help is available, a person will naturally seek help from a quack who offers some promise of cure. To this could be added another category consisting of socially marginalised groups that expect to be ill-treated by the system e.g. CSWs, unwed mothers, STD patients etc.

An HIV positive person or an AIDS affected person would fall into any of these categories:

- When briefed that there was no cure for AIDS, the person would only dream of a miracle.
- He/she may know that nobody can really cure him but would be restless because of the prospects of lingering death and want some immediate relief.
- He/she would certainly be desperate enough to cling to any straw that he/she thinks would save his/her life. Thus the counsellor must make the counselee aware of these feelings and drives so that the counselee does not get misled or cheated by such quacks.

In some cultures, spiritual or traditional healers may not know how HIV infection is transmitted. They might even harm an infected person with their remedies and cause the infection to continue to be transmitted. The counsellor should make every effort to establish contact with them and explain to them the modes of HIV transmission, the nature of HIV transmission and AIDS so that they can modify their practices.

Culturally Determined Rituals for Death and Cultural Sources

Often, the counsellor has to help clients and their families deal with major changes in behaviour and living arrangements, disablement or disfigurement, or impending death. Clients will react to HIV infection or the possibility of it, or to clinical AIDS, in various ways - fear of abandonment, or pain, disfigurement, and helplessness. How these fears are expressed will be partly determined by the culture.

Different cultures have different rites for terminal illnesses, death and bereavement. The counsellor must 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 in spiritual matters.

Cultural Attitudes Towards Prevention

The counsellor who appreciates the influence of tradition and culture can establish with a worried person or with a HIV-infected individual and family:

- a common definition of the problem;
- an acceptable way of explaining it; and
- a culturally acceptable way of handling it.

As HIV infection is transmitted sexually, cultural and personal attitudes towards sexuality and other preventve options are extremely influential. The counsellor must also realize that some people may hesitate for cultural, religious or moral reasons to consider the use of condoms, or any form of contraception. It is particularly difficult to change culturally and traditionally sanctioned behaviour, such as male extramarital sexual relationships. The justification for change in this context must be compelling e.g., the protection of children from infection, or from deprivation or destitution which would be a result of the bread winner's death at an early age.

Facts alone will often not be enough to change cultural attitudes, which must then be accepted and the client helped to find other means of protection -for example, by weighing the emotional costs and consequences of sexual abstinence against those of a morally proscribed practice such as using condoms.

The attitudes of others, including those of the public authorities, towards prevention and care, must also be considered, since these attitudes can determine whether the client will change behaviour and cooperate in treatment. Fear of social stigma may lead to denial, resignation or fear of abandonment.

Maintaining sensitivity to cultural issues and differences can be very demanding. The counsellor must try and understand the sort of life another person has led, which includes knowing the ideas, ideals and symbols that define the person's identity and means of coping with misfortune.

Counselling can involve discussing behaviour or ideas that may be taboo in the counsellor's culture; it can go beyond tolerating differences to a genuine appreciation of the critical importance to the client of something to which the counsellor may be very hostile. Even a very experienced counsellor will sometimes feel shocked or offended. Counselling requires self-discipline, as well as self-knowledge, familiarity with various cultures and beliefs, and openness to different views and interpretations.

PREVAILING SOCIAL, POLITICAL AND HEALTH RELATED ATTITUDES

Trainees are members of the societies they live in and are influenced by prevailing cultural, social and religious attitudes. This can sometimes affect their attitudes towards those they care for and lead to conflicts with professional guidelines. Some factors are:

Health behaviour and beliefs

How people view and understand illness and their traditional practices for prevention, and care of illness are important factors. If, for example, people believe in balanced nutrition as a disciplined way of life (life style) and practice accordingly, it would positively effect prevention and even in ceses with HIV infection.

Cultural beliefs, values and practices also affect people's behaviour. Implication of such beliefs and practices can be enormous and they may partly determine whether people are vulnerable to HIV. For example if cultural values advocate monogamous, faithful sexual relationships, and if the social practices confirm to these values, the odds against people being vulnerable to HIV infection would be low.

The Social and Political situation

Certain kinds of socio-political environments marginalise vulnerable weaker groups. It increases their vulnerability to HIV infection. Some of these groups are migrant labour, street children and such others. The life styles of those who belong to these groups also makes them vulnerable to HIV infection.

Availability of Health Care

This also determines the prevention and care-related practices in communities. Modern health care is not easily accessible to many. If accessible, it is very costly and still not within their reach. These groups turn to traditional medicine systems and sometimes even to quacks. As primary health care provided by the state is still not accessible to many, they also turn to the private sector which has a commercial base. Problems resulting from this situation are indiscriminate use of injections, of blood transfusions and low reliability of injection control methods. The utilisers are exposed to a risk of HIV infection.

MARGINALIZED GROUPS

Many social groups have become marginalised because of socio economic reasons. They face social stigma and thus become more and more alienated from the mainstream of society. The access to health care and other resources (eg. education) is reduced. These groups are vulnerable to HIV infection. The issues these groups face in relation to HIV infection are complex.

Commercial Sex Workers

Very often this is the group which is socially and economically at the lowest rung of society. Access to information about health care regarding prevention is almost absent. Due to the social stigma attached to this group, members may keep away from seeking this information. At the same time their occupation makes them a high risk group for HIV infection. Very few have the choice to change their life style due to the exploitative system and become the "reservoir of HIV infection". As eunuchs indulge in commercial sex they too are at risk of HIV infection. The community strives to maintain privacy and thus often has no access to health care.

Street Children

Exposed to hard living on the street the children very often are the target of sexual abuse. Drug abuse is another hazard they face, apart from poor health and low nutritional status. This group becomes highly vulnerable to HIV infection. At the same time, access to services becomes difficult as they are looked at with suspicion by the society.

Homosexuals

This group has a social stigma and was not even recognised openly uptil now as their homosexual orientation was considered perverse and unnatural. However, urban and literate homosexual population has access to information. That apart, very little is known about the rural homosexual population.

Intravenous drug users

In certain geographical regions, this group has been identified as one of the major high risk groups in India. The danger of HIV infection is through their group norm of needle sharing. The group is not easily identifiable, as they remain hidden due to stigma attached to drug ause, and is difficult to reach. Many of them may also be of a sexually active age, thus increasing their vulnerability to HIV infection. The growing criminal nexus with drug abuse points out towards the increase in intravenous drug-use.

Clients of sex workers

Research has shown that this group prefers sexual practices which increase the danger of HIV infection (for example anal sex without condoms). The group may largely comprise of sexually active men of all ages. An added risk is that they may pass the infection to their spouses or regular partners.
There are some other groups who also need special attention. They are:

Professional (paid) blood donors

The cultural and social beliefs do not encourage blood donation, thus creating a need for the existence of this group. This is usually a socially alienated group due to other behaviours like drug-abuse. Many of them also indulge in multi-partner sex. They are highly vulnerable to HIV, and pass it on to their recipients.

Blood Product recipients

Illness like thallacemia, haemophillia, sickle cell anaemia are common in certain ethnic groups, for example certain tribals. The nature of their illness necessitates receiving blood and blood products regularly for survival, thus making them vulnerable to HIV infection. The groups are not easily identified and are geographically dispersed. Many of them are ignorant of their own vulnerability. This ignorance may lead to unsafe sexual practices, and then passing on the infection to their spouses.

Some of these above groups have been given further attention in Module 5 on 'Special Issues'.

Suggested Reading

Derald. W. S. (1981): Counselling the Culturally Different: Theory and Practice. John Wiley & Sous.

Panos Dossier (1988): Blaming Others : Prejudice, race and worldwide AIDS London : Panos Publications

Sabatier, R. (1990): The Third Epidemic : Repercussions of the fear of AIDS London : Panos Publications.

ACTIVITY 1: Small Group Work: Exploring Attitudes

Time: 50 minutes

Objective:

This activity gives an opportunity to trainees to explore and clarify their own attitudes towards HIV and AIDS.

Procedure:

Divide the trainees group in smaller discussion groups of 3-5 members. First have each member fill in the sheet for himself/herself (allow 10 mins.). Then ask each group to elect a leader who can record the group's ideas after all members share and discuss their responses and report them back to the class. Each group member will need a copy of the statements listed in **worksheet 1**. It is important that the trainer does not seek to correct or criticize views that he or she disagrees with at this stage, but allows free expression of them. The trainer then discusses the following issues with the group by going over the points given below: (allow 20 minutes).

Points of discussion:

- Why are these called controversial statements?
- Have you heard of such statements being made by people? Which ones are most frequently used?
- Did you feel comfortable discussing your views with your partners?
- Were you surprised when your partner disagreed with you?
- Did you change any of your views after listening to your colleagues?

WORK SHEET 1

Controversial Statements

In the boxes fill in an (A) for agree and (D) for disagree based on your opinions about each statement :

- ❑ Women with HIV infection should not have children.
- ❑ People with AIDS should not be allowed to continue work.
- ❑ AIDS is mainly a problem of people with immoral behaviour.
- ❑ Men who have sex with men indulge in abnormal sexual behaviour.
- ❑ People with HIV infection should be isolated to prevent further transmission.
- ❑ It is a collective responsibility to care for people with HIV infection.
- ❑ I would feel uncomfortable inviting someone with HIV infection into my house.
- ❑ Surgeons should screen all patients for HIV infection before surgery.
- ❑ I would feel uncomfortable discussing sexuality with a person of the opposite sex.
- ❑ Intranenous drug users should compulsorily be tested for HIV.
- ❑ It is alright for men to have sex before marriage.
- ❑ School children should not be educated about safer sex.
- ❑ Women should never have extra-marital sexual relations.
- ❑ All professional blood donors should be jailed.
- ❑ It is difficult for male counsellors to talk to women clients about condom use.

ACTIVITY 2 : Briefing

Time: 60 mins.

Objective:

The purpose of this activity is to help the trainees to gain a better understanding of the role that values, attitudes and cultural isues play in relation to HIV/AIDS.

Procedure:

The trainer highlights the points brought out in the content section of this module, and that different backgrounds have different values which influence attitudes towards HIV infection and AIDS. Trainer should draw from experiences of the trainees.

ACTIVITY 3: Need to be Non-judgemental

Time: 15 minutes.

Objective:

The purpose of this activity is to help trainees understand the need to be non-judgemental in counselling.

Procedure:

Using the material presented in Activity 2, the trainer explains how being judgmental adversely affects counselling. He/she gives the following examples:

Statement by Ajay (a college student)	:	"I went to a prostitute last night. Do you think I could have contracted AIDS?"
Vikas's (a friend) Reaction	:	"What can you expect if you indulge in this bad habit?"
Statement by Sheela (a student)	:	"I am going to have an arranged marriage next month, but my parents and my future husband do not know that I am having an affair with a boy in my college. I don't know what to do!"
Teacher's Reaction	:	"I am ashamed of you. Shall I tell your parents?"

Statement by Ravi (a patient)	:	"For the past one year I have been taking drugs. Now, I hear that people who take drugs get AIDS. Is that true?"
Doctor's Reaction	:	"Of course, it is true. You should never take drugs."

Now ask the participants to volunteer to respond in a non-judgmental way to each of the three statements given above. They may either verbalize or write their responses. Ask a few of them to call out their responses for each statement and acknowledge the ones which are non-judgmental and supportive.

ACTIVITY 4 : Case Discussion

Time: 60 minutes

Objective:

Trainees need to be able to identify and pick out the social and cultural issues by examining the following cases.

Procedure:

Trainees break up into 3 groups. Each small group discusses a case scenario given to them by the facilitator using the discussion questions/guidelines given below. After 30 minutes, they come to the bigger group where each small group shares their case scenario and findings with the big group. Allow 30 minutes for discussion.

Case Scenarios :

#1 Satinder 40, is married and has just found that his wife is HIV positive. She had a blood transfusion six years ago during an operation. They have two children. Satinder is planning to send his wife to the village and marry again, so that the house and children will be looked after.

#2 Vandana is working near a cinema theatre selling cinema tickets in black. She has to do some work as she comes from a very poor slum family. The person who controls the black market has sexual relations with Vandana. She is HIV negative.

#3 Manish is a 24 year old youth. He is an alcoholic and visits prostitutes. He is HIV positive. He refuses to treat his alcoholism and neglects advice about condom use. His mother is worried about looking after him. Should his vessels and clothes be kept separately?

Points of discussion:

- Is this situation acceptable?
- What are the implications?
- Who is accountable/vulnerable?
- What kind of resources can be mobilised to help the situation?

ACTIVITY 5 : Review Questions

Time: 10 mins.

Allow 10 minutes to the trainees to fill **worksheet 2.** Trainer should discuss some of the likely answers with the trainees.

WORK SHEET 2

Review Questions

1) Why is it important for a counsellor to examine and understand his/her own attitudes?

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

3) What are some of the cultural attitudes and beliefs that influence health in India?

MODULE 3
HIV/AIDS COUNSELLING : PRINCIPLES, SKILLS AND METHODOLOGY

EXPECTED OUTCOMES

The trainees will :

1) gain a clear understanding of the essential principles and goals of counselling as well as the basic counselling stages and activities;
2) develop a clear perspective of objectives and methodology of HIV/AIDS counselling;
3) develop effective verbal and non-verbal communication skills in relation to the counselling process;
4) critically review the ethical and legal issues related to HIV testing and counselling

MODULE AT A GLANCE
TOTAL TIME - 8 HRS 55 MINS

❖ **SECTION 3A**

CONTENT SECTION

COMMUNICATION SKILLS IN RELATION TO COUNSELLING

ACTIVITY SECTION

COMMUNICATION SKILLS	:	20 mins
PAIRED EXERCISE	:	20 mins
ROLE PLAY	:	40 mins
CONTENT PRESENTATION	:	20 mins
BRAINSTORMING	:	15 mins

❖ **SECTION 3B**

CONTENT SECTION

COUNSELLING : BASIC PRINCIPLES AND GOALS

ACTIVITY SECTION

BRAINSTORMING	:	25 mins
CONTENT PRESENTATION	:	1 hour 30 mins

❖ **SECTION 3C**

CONTENT SECTION

HIV/AIDS PREVENTIVE AND SUPPORTIVE COUNSELLING

ACTIVITY SECTION

GROUP WORK	:	45 mins
GROUP WORK	:	45 mins
ROLE PLAYS	:	1 hour
GROUP DISCUSSION	:	30 mins
GUIDED IMAGERY	:	1 hour
ROLE REVERSAL (Optional)	:	25 mins

❖ **SECTION 3D**

CONTENT SECTION

ETHICAL AND LEGAL ISSUES RELATED TO HIV

ACTIVITY SECTION

CASE STUDIES	:	45 mins
REVIEW QUESTIONS	:	20 mins

OVERVIEW

Counselling is both an art and a science, and requires not only a knowledge of the subject matter but also self-knowledge, self-discipline and self-respect. It becomes an art when the counsellor masters the use of various skills to foster the relationship of counsellor - client and supports the client in achieving autonomy and high self-esteem. Counselling almost always involves communication about sensitive isues and good communication depends on careful observation. Throughout each session, the counsellor pays careful attention to both verbal and non-verbal messages. Some essential communication skills (active listening, asking effective questions, paraphrasing, reflecting feelings, appropriate use of silence) are employed to ensure that the client and counsellor correctly interpret each other's messages and that their responses are appropriate and satisfying. Some advanced counselling skills are also used once the relationship has become deeper and complex issues are being worked through; these skills range from interpretation, focussing to confrontation and modelling behaviours.

Counselling is a special form of interpersonal communication in which feelings, thoughts and attitudes are expressed, explored and clarified. The approaches or models of helping may vary but certain essential principles, including empathy, confidentiality and time management are common to all counselling situations. Each counselling process is aimed at certain goals. One can also observe specific stages in this process which can be termed as: the beginning stage, middle stage and end stage or closure, each of which calls for certain actions and tasks to be undertaken by the counsellor.

HIV/AIDS counselling has two general objectives - to prevent further spread of the infection (by doing risk reduction counselling, pre-test counselling and post-test counselling) and to provide psychosocial support to those already infected and their families (by doing supportive counselling). Helping people assess their degree of risk of infection due to their behaviours, preparing them for taking the HIV - screening test, educating and informing them about the syndrome, explaining and supporting them through the result - declaring stage, guiding them towards safer sex practices and ways to reduce further risk are all part of a counsellor's work during preventive counselling. . As a supportive HIV/AIDS counsellor, the counsellor focusses on supporting and helping clients to cope with the impact of the infection on their lives and relationships, deal with progress of the infection, come to terms with terminal illness and deal with feelings of death and dying, and helping family members to deal with their reactions as well as their caring for the infected family member.

HIV/AIDS is a complex issue and brings to the forefront many issues involving ethics, human rights and legal statutes. The critical issues that counsellors need to examine and confront are: mandatory testing, informed consent, confidentiality, partner notification and equal opportunity provisions.

SECTION 3A

COMMUNICATION SKILLS IN RELATION TO COUNSELLING

INTRODUCTION

HIV/AIDS prevention counselling may be the only practical means for promoting change and adoption of long-term low risk behaviours. Counselling programs can identify and promote low risk behaviours, and, provide emotional and psychological support to people with HIV infection, their families and friends. In order to do this effectively, counsellors have to focus and work on their communication skills as communication is the only way counsellors can interact with clients to evaluate, to focus on and to facilitate change. Good communication depends on careful observation, correct interpretation of client's messages, and making responses that are consistent and helpful.

Communication is at two levels, verbal and non-verbal. Verbal is the most obvious and recordable whereas the bulk of communication is generally non-verbal. Non-verbal communiction is mostly through tone of voice, posture etc. The non-verbal mode is a very powerful means of communication. Looking out for both these components actively, may help the counsellor to see beyond what the patient is obviously stating. These skills can be developed by practice and receiving feedback from colleagues. The essential skills are described in this section.

ESSENTIAL COMMUNICATION SKILLS

1. Non-Verbal Communication

Non-verbal communication is an important element in letting clients know that they are being attended to, heard and understood. Counsellors convey this to the clients through:

- body language (for e.g. leaning forward to convey interest)
- calm body posture (no fidgeting, etc.)
- frequent eye contact (but no intense staring)
- encouraging conversation cues (for e.g. nodding, smiling)
- mirroring clients' energy or emotional level

2. Active Listening

Active listening demands extremely concentrated listening on the part of the counsellor, who must pay acute attention to the client's verbal disclosures, non-verbal cues and feelings that are indirectly expressed. Counsellors must maintain and communicate their active involvement with the client through non-verbal communication such as eye contact, nodding the head, etc. Using verbal skills like repeating the last few words of the client's statements, encouraging words like "Yes, I see," and allowing the client to complete the incomplete sentences are very helpful. Attentive behaviour enhances the client's self-respect, establishes a safe atmosphere, thereby facilitating free expression of whatever is in the client's mind.

3. Asking Effective Questions

Counsellors use questions to obtain specific information, to help the client communicate clearly, to encourage exploration and clarification of thoughts, feelings and attitudes. Open-ended questions (which require more than a yes or no answer) encourage this type of discussion and communication because they allow for any response. Closed ended questions, by contrast, only allow for a yes or no answer and discourage discussion or exploration. Counsellors probe the client through questioning to fully explore and discover the core issues of the client's situation.

Examples of open-ended questions :

"Would you tell me more about how you are feeling? Can you tell me more about that?"
"What was that like for you?" "In what other ways may difficulties come up in your life if you don't change your sexual behaviour?"

4. Paraphrasing

Counsellors can paraphrase or restate in their words what the client said in order to let the client know that her or she has been heard. Counsellors can paraphrase both content and underlying feelings. This can help to clarify what the client has expressed. When employing this skill, the counsellor attempts to tell the client the essence or content of what the client has just said.

Example:

"So, what you are saying is that you can't imagine how you could have been exposed to HIV."

5. Identifying and Reflecting Feelings

Counsellors can help clients identify and clarify their feelings and reactions by listening to the feelings being described and then reflecting them back to the client. Reflecting gives the counsellor the opportunity to interpret, and then compare with the client, what the client has expressed in terms of his/her emotional state. The counsellor recognizes the client's feelings (such as hur., anger, fear) and indicates this in a direct way to let the client know : "Your feelings are very strong, and I accept them, and I accept you".

Example:

"You seem to feel very angry with your husband for becoming infected with HIV, and very worried about him at the same time.
Can you tell me more about your feelings toward your husband?"

6. Appropriate use of silence

Silence in a counselling session is important at times. It gives the client an opportunity to reflect, integrate feelings, think through an idea or absorb new information. It is not always comfortable to allow the silence to continue, but counsellors should not interrupt it prematurely because of their own discomfort. There can be no specific guidelines as to when silence is helpful but counsellors should consider whether they are motivated to use it because of their own discomfort, or as a positive intervention with the client.

ADVANCED COMMUNICATION SKILLS

1. Focussing

It is easy for the client to get sidetracked in the counselling session because many thoughts and feelings emerge. The counsellor needs to help the client focus on the most important issues at hand. The aim of focussing is to prioritize what needs immediate attention and is the main task versus what can be put off until later; it brings clarity and perspective to counselling.

Example:

"Let us come back to the issue of safer sex practices."

2. Interpretation

Often people will avoid focussing on the real problem and will talk around the issue. The counsellor helps to establish what is relevant by emphasizing the important points. Interpretation goes beyond what is explicitly expressed to the meanings and feelings being implied by the client's comments and which are somewhat below the surface of the client's awareness. It redefines or brings out more clearly feelings which are at the edge of awareness.

Example :

"Of all the things you talked about today, it seems to me you are most concerned about ....."

3. Problem Solving

Counsellors often help clients to solve problems. This is most effectively done by allowing the client to state the problem and then clarifying and defining it from the counsellor's point of view. The counsellor may suggest possible solutions, facilitate the client's exploration of these solutions and their consequences, as well as help the client in making decisions and carrying out the decided solutions. Here, the counsellor should guard against making assumptions about what is problematic to a particular client and should never attempt to solve the problem for the client.

4. Repeating and Reassuring

At times of stress and crisis, people do not always understand at once everything they are told because they may be overwhelmed or in a state of denial. The counsellor needs to be repetitive at such moments. He/she should repeat statements of support or factual information as often as necessary until he/she is sure that the client understands clearly what is being said or what needs to be done about risk behaviour, illness and health management. The counsellor also needs to reassure the client, verbally and non-verbally, that he/she is accepted and, whatever he/she is feeling is normal and understood (by the counsellor).

5. **Confronting**

Confrontation involves a direct examination of incongruities or discrepancies, in the clients' thinking, feeling and/or behaviour. It calls attention to possible self-deception, games, denial, resistance and evasion being done by the client. The counsellor shows how thoughts, actions/behaviour and consequence are related and encourages the client to adopt new, less destructive ways of behaviour. As it is a highly intrusive skill, timing is very important and it should be delivered in a warm and caring manner.

Confronting the client may be an effective response when an issue is being denied or has not come out into the open. Counsellors need to confirm the truth and facts of what the client is facing and experiencing, even when they may want to protect them or cushion them from harsh reality.

Example:

"I know that it is difficult to understand how you can feel healthy,
but you have this virus inside of you that you are capable of transmitting to others.
And if you do not adopt safer sex practices your wife could become infected."

6. Supporting and Modelling Behaviours

Counsellors can support and reinforce specific behaviours by modelling them for and with the client. For example, if a goal of the counselling session is for the client to improve communication skills, the counsellor can model clear and direct communication when he or she interacts with the client. When the client responds with clear and direct communication, the counsellor can comment on and support this type of dialogue.

7. Summarizing

People who are in shock or in a safe of anxiety talk very fast, seek more information and ask a lot of questions such that the counsellor cannot keep pace or absorb all of the reactions. The counsellor should then interrupt the session and summarize what has been said. It becomes a time to pause, reflect on what has been discussed so far and to propose a similar or new direction. A summary puts together a number of the client's spoken paragraphs, or an entire phase of a session or may even be used at the end to cover the full session. At the end of each session, the counsellor should summarize the salient points of discussion and highlight decisions which have been made and need to be acted on.

Example :

"So far we have discussed safe sex practices and your feelings about adopting some of them.
Do you feel we have completed discussing this topic for now?"

SOME COMMON COUNSELLING ERRORS

The principles of counselling are easy to learn but can be difficult to apply. It requires a combination of self-knowledge and constant practice to gain mastery over the principles discussed throughout this Manual. People who understand their own prejudices, have incorporated the values and attitudes of counselling, are flexible and adaptable, and have mastered the basic principles are likely to become effective counsellors. However, even counsellors who possess all these qualities can make mistakes. This could be due to fatique, acceptance of an old stereotype, a client's persistent rejection of information or guidance, or some other cause. Some of the counsellor's interventions readily support the counselling process, while others can bring it to a halt very abraptly.

Some common counselling errors to watch out for and avoid are:

1. Directing and leading - controlling rather than allowing and encouraging the client's expression of feelings and needs.
2. Judging and evaluating, as shown by statements that indicate that the client does not meet the counsellor's standards.
3. Moralizing, preaching, and patronizing - telling people how they ought to behave or lead their lives.
4. Labelling and diagnosing, rather than trying to find out the person's motivations, fears and anxieties.
5. Unwarranted reassurance, diverting a client's attention from an issue and humouring the client -trying to induce optimism by projecting the clients problem as minor issue.
6. Not accepting the client's feelings - saying that they should be different.
7. Interrogating - using questions in an accusatory way. "Why" questions almost always sound accusatory.
8. Encouraging dependence - increasing the client's need for the counsellor's continuing presence and guidance.

Another important area where errors can occur is in the cultural context and the background of different clients. It is largely in its use of words, or language, that counselling is adapted to culture. Communication in counselling takes the form of speech (verbal) or of body language (non-verbal). A counsellor may sometimes unknowingly speak or behave in ways which a client from another culture interprets as rude, unusual or even threatening. This may cause the client to become silent and withdraw from the session. When this occurs, the counsellor needs to become aware of it, comment on it, encourage an explanation, and change or adapt the counselling style.

A number of behaviours, listed as supportive and non-supportive, are given in the following two tables. These are only reference pointsn and it should be remembered that there will be cultural variations among these in some cultures. Counsellors will need to take note of the types of behaviour that would be supportive or non-supportive in counselling in their respective cultures. The counsellor must be secure enough in his/her self-concept to admit unfamiliarity with a client's culture (when that is true) and to question the client in order to decide how to conform to the client's cultural norms.

TABLE 1

Examples of Supportive Behaviour in a Selected Culture

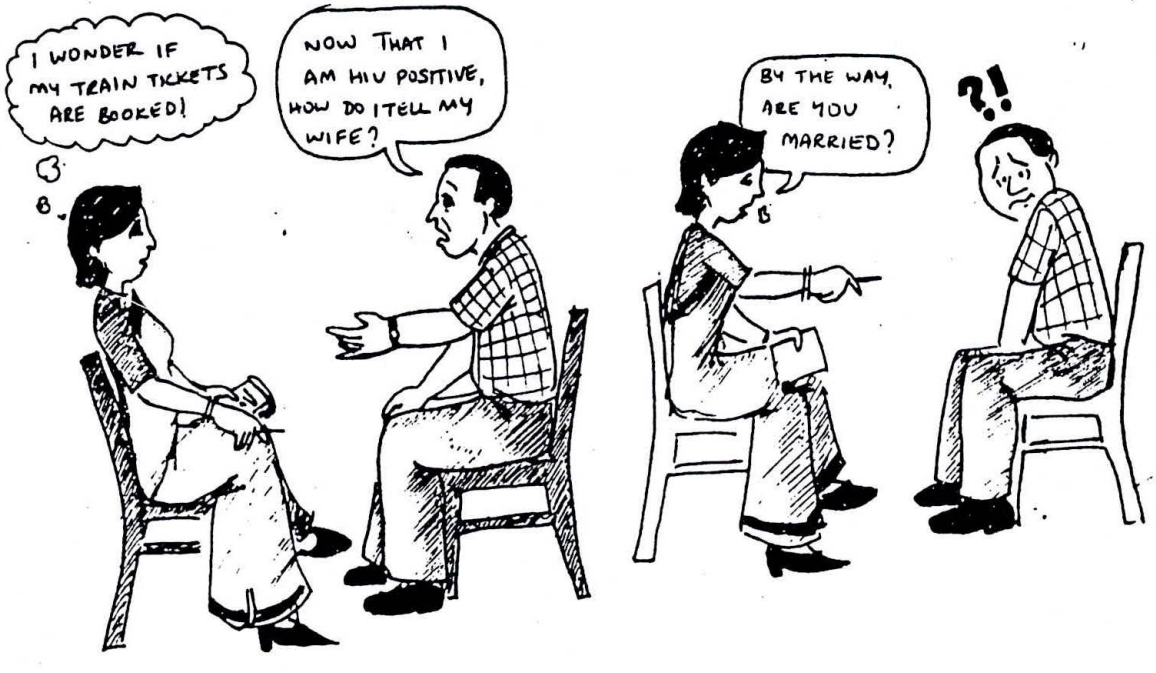
Verbal	Non-verbal
Uses language that the client understands	Uses a tone of voice similar to the client's
Repeats in other words and clarifies client's statements	Looks client in the eye
Explains clearly and adequately	Nods occasionally; uses facial experessions
Summarizes	Occasional gestures
Responds to primary message	Suitable conversational distance
Encourages by saying: "I see","yes, go on"	Does not speak too quickly or too slowly
Addresses client in a manner appropriate to the client's age	
Gives needed information	
Uses humour or other means of reducing tension	
Does not criticize or censure the client	

TABLE 2

Examples of Non-Supportive Behaviour in a Selected Culture

Verbal	Non-verbal
Advising	Looking away frequently
Preaching	Inappropriate distance
Blaming	Sneering
Cajoling (persuading by flattery or deceit)	Frowning, Scowling and yawning
"Why" questions	Unpleasant tone of speech
Directing, demanding	Speaking too quickly or too slowly.
Straying from the topic	
Patronizing (condescending) attitude	

Being distracted during counselling is also a non-supportive behaviour.



ACTIVITY 1 : Communication Skills

Time : 20 mins

Objective :

The purpose of this activity is to introduce the participants to some essential communication skills which enhance counselling. The need to pay attention to non-verbal communication (body posture, facial expression, etc.) and active listening in the initial stage of the counselling relationship should be emphasized strongly. The skill of questioning is also practiced by the participants in this activity.

Procedure:

The trainer asks the participants to find a partner and choose a comfortable place to sit together. There should be an attempt to sit as far as possible from other pairs of participants, if the size of the room permits. The pairs are asked to decide among themselves as to which person will be the "speaker" and which the "listener" for this exercise.

After all the pairs have decided their roles, the trainer instructs the "speakers" to choose any issues/thought/experience that is alive in their minds/lives and speak for 3-4 minutes on the topic. The "listener" has to just listen and should not use words or non-verbal communication (facial expression, eye contact etc.) to respond and indicate his/her interest in the speaker's conversation. The trainer then calls for the speaker to start. After 4 minutes, the trainer asks all the speakers to stop and requests the listeners to ask the respective speakers 1-2 relevant questions which seem very important, only based on the speaker's conversation/comments.

The trainer emphasizes that the questions should be as open-ended as possible and not begin with a "why" ("why" questions tend to put a client on the defensive as they make him/her feel cornered or having to justify his/her feelings, thoughts or statements). The trainer allows 5-10 minutes for the listeners to think of and ask the questions of the speakers. The full group is then re-assembled and the trainer conducts a general discussion.

Points of Discussion:

- For those acting as speakers : How did the speakers feel to have someone's undivided attention and to be able to speak for four minutes without any interruptions?

- For those acting as speakers : Did they feel the listener was listening to them? What did the listener do to indicate he/she was listening (or, did not seem to be paying attention - both kinds of responses are important to explore).

- For those acting as speakers : Upon hearing the questions posed by their listener, did the speaker in the pair feel that his/her topic or feeling had been understood accurately by the listener? Did the questions help the speakers understand their own thoughts/feelings?

- For those acting as listeners : How did the listeners feel about conveying their interest only in non-verbal ways?

- For those acting as listeners : How would it have been different if they had been talking and responding actively from the start?

- For those acting as listeners : Was it easy for the listener to formulate the questions? If no, what were the difficulties?

The trainer concludes by stressing the importance of active listening, relaxed and attentive body posture and the art of questioning in making clients feel comfortable and uninhibited.

ACTIVITY 2: Paired Exercise : Paraphrasing

Time: 20 mins

Objective:

This exercise helps participants practice the skill of paraphrasing.

Procedure:

Each trainee should find a partner and choose a subject on which they and their partner apparently disagree from the list of topics given below. Trainee "A" can begin by making 1-2 statements on the subject. Trainee "B"s job is to paraphrase the idea back, without adding any judgement or interpretation. The facilitator gives a brief explanation of the meaning and use of "paraphrasing" as a communication skill.

Trainee "A" should then give feedback to their partners whether his/her response was accurate. If there was some misunderstanding, trainee A should make the correction and then trainee "B" should feed back a corrected, new understanding of the statement.

Once "A" has understood his/her partner correctly, reverse roles, and have Trainee "B" make 1-2 statements in response to "A's" statements. Now trainee "A" should paraphrase his/her partner's statement. Once both Trainee "A" and "B" are satisfied that they have been understood, discuss the following questions:

- As a listener, how accurate was your first understanding of the speaker's statement?
- How did your understanding of the speaker's position change after you used paraphrasing and received feedback?
- How did your feel at the end of the conversation? How does this feeling compare to your usual emotional state after discussing controversial issues?
- How might your life change if you used paraphrasing at home? At work? With friends?

LIST OF TOPICS :

1._____Women with HIV infection should not have children
2._____People with AIDS should be allowed to continue work.
3._____AIDS is mainly a problem in persons with immoral behaviour.
4._____Men who have sex with men indulge in abnormal sexual behaviour.

ACTIVITY 3: Role Plays : Reflection of Feelings

Time : 40 mins

Material : "Client Statement Worksheets" pencils, paper, markers, tape

Objective :

The purpose of this activity is to practice identifying and reflecting feelings. People have many emotional reactions to HIV infection. These reactions often affect their behaviour, their ability to make decisions, and their relationships with family and friends. However, clients often do not understand their own feelings. Counsellors can help clients identify these feelings so that they can cope with them better. One way to do this is by naming the feelings for the client. This skill is called **reflecting feelings**. For example, a counsellor might say to a client, "You say everything is fine, but you look very sad". This communications technique can help clients identify their emotions and talk more freely about what is bothering them.

Procedure:

Ask participants to complete the "Client Statements" **Worksheet 1**. Instruct participants to read each client statement, and write down the feeling or feelings which might be behind what the client is saying in each statement. Next, they are to write down a possible reason the client might be feeling this way. Give participants approximately 10 minutes to complete the worksheet. After the participants have finished, write on a large piece of paper the following formula:

"You feel _____ because _____.
(feeling word) (reason)

Explain that counsellors can use this type of statement to identify and then reflect client's feeling. Explain that it is important for each counsellor to find a comfortable way of expressing this information. On a separate sheet of paper, write the following alternative phrases:

"You seem _____ because _____.
(feeling word) (reason)

"I wonder if you're _____ because _____.
(feeling word) (reason)

"Do you feel _____ because _____.
(feeling word) (reason)

"It seems you are feeling _____ because _____.
(feeling word) (reason)

Ask participants to brainstorm other phrases they might use to identify and reflect feelings. Next, ask each participant to choose a partner. One partner should role play the client and the other, the counsellor. Explain that participants will be practicing identifying and reflecting feelings using the **"Client Statements Worksheet 1"**. The "client" is to read statement # 1 from the worksheet. The "counsellor" should look at his/her own notes on the "Client Statement" worksheet and use them as well as the feelings the "Client" is now presenting to respond with a phrase that reflects the "client's" feeling.

When this is completed, the client and counsellor switch roles for statement # 2. The pairs are to continue this process until they have completed all 7 statements on the worksheet. Encourage participants to try different phrases each time they play the role of counsellor. Ask the pairs to briefly discuss this activity and give feedback to each other. Once completed ask participants to return to the large group and ask a few discussion questions and close the exercise with a summary of the major points.

Points of Discussion:

- How easy and comfortable did you feel identifying and reflecting feelings?
- What felt uncomfortable?
- How will identifying and reflecting feelings be useful for the client?
- What were the differences in identifying feelings in the "Client Statements Worksheet" and during the live role plays?

Summary of Major Points

- Clients give many verbal and non-verbal clues about their feelings without directly telling the counsellor what they are feeling.
- When the counsellor puts the client's feelings into words and connects the feeling to a real problem or situation, the client becomes more aware of his feelings. This will help him make effective decisions about his future.

WORK SHEET 1

Client Statements

INSTRUCTIONS : For each client statement write down the feeling or feelings you think the client may be experiencing and a possible reason why he/she is feeling this way.

1. "I was so sick in bed. My mother was the only person at home. Instead of taking me to hospital, she went to do business at the marketplace".
   Feeling(s)_____
   Reasons: _____

2. "Why is my antibody test taking so long? Why isn't it here yet? You said it would take 2 or 3 weeks. It has already been 3 weeks. Do you think that means it is positive?"
   Feeling(s)_____
   Reasons: _____

3. "Why, in the past when I visited home, everyone used to greet me. Now, since I have been fured nobody does. Now I know who my true friends are".
   Feeling(s) _____
   Reasons: _____

4. "I can't ask my husband to use condoms. He will refuse. He will think I am accusing him of something or that I am unfaithful".
   Feeling(s) _____
   Reasons: _____

5. "Oh no! How can I have this virus, HIV? I just got promoted. What am I going to do?"
   Feeling(s) _____
   Reasons: _____

6. "I can't decide whether to have the HIV antibody test. I'm not sure. What do you think I should do? I really don't know....."
   Feeling(s) _____
   Reasons: _____

7. "I was using condoms with other girls, but not with my wife. I didn't think I had to worry about HIV. I wish I had listened to what my wife was telling me".
   Feeling(s) _____
   Reasons: _____

ACTIVITY 4: Presentation : Other Communication Skills

Time : 20 mins

Objective:

This presentation helps the participants learn about other advanced communication skills that have not been covered in the exercises. It also puts into focus the real-life stages and processes of counselling.

Procedure:

The trainer gives a brief presentation, with examples, on the remaining counselling skills described in the content section.

ACTIVITY 5: BRAINSTORMING : SOME COUNSELLING ERRORS

Time: 15 mins

Objective:

This brainstorming calls attention to the factors that aid counselling and those that may be non-supportive including personal attitudes, qualities and communication issues. It also allows for an expression of the participants' understanding of counselling uptill now.

Procedure:

The trainer makes two columns on a flipchart or black board with the two headings "Supportive Communication and "Non-supportive Communication". He/she asks the participants to brainstorm and call out those behaviours or attitudes or verbal messages that could be seen as "supportive" by a client and the trainer lists them on the flip chart/board.

He/she then invites the group to list out those behaviours or verbal messages that could be viewed as "non-supportive" or "negative" by a client and lists these in the second column. The trainer reviews both the columns and then uses **OHPs # 1, 2 & 3** to highlight the point further, bring out elements that may have got left out and review some counselling errors for participants to avoid.

OHP # 1

SUPPORTIVE COMMUNICATION

VERBAL

Using language that the client understands

Conveying interest - **remembering details**

- **addressing client by name**

Conveying acceptance - **non judgemental attitude**

Conveying willingness to help

Paraphrasing - **determine basic message**

- **rephrase in fewer words**

Encouraging statements - **'yes', 'I see', 'go on'**

Reflection of feelings - **focus on feeling and content**

Giving needed information

Addressing client in a manner appropriate to his/her age

Using humour or other means of reducing tension

Speaking audibly, slowly, clearly

NON-VERBAL

Maintain suitable conversational distance

Maintain eye contact

Attentive body posture

Nod appropriately

Use facial expressions

Use occasional gestures

OIIP # 2

NON-SUPPORTIVE COMMUNICATION

VERBAL

Advising

Giving moralistic judgements

Criticizing or blaming

Scolding or threatening

Discussing your personal problems

Interrupting

Imposing your own values

Rejecting

Premature interpretations

Excessive curiosity

Asking question in a direct and embarrassing manner

Forcing unwilling disclosures

Taking sides

Arguing

Controlling

Labelling and diagnosing

Unwarranted reassurance

Not accepting patient's feelings

Interrogating

Encouraging dependence

Talking too much

OHP # 2 (Contd.)

NON-SUPPORTIVE COMMUNICATION

NON-VERBAL

Looking away frequently

Inappropriate distance

Looking bored, irritated

Fidgeting, yawning, looking at the watch

Writing while client is talking

Unpleasant tone of voice

Sneering

OHP # 3

FACTORS RELATED TO UNSUCCESSFUL COUNSELLING

CLIENT RELATED

- Totally unmotivated client
- Unrecognized psychiatric illness
- Overwhelming crisis situation
- Limited personal resources

THERAPIST RELATED

- Inexperienced
- Excessive therapeutic ambitiousness
- Pessimism
- Unconscious hostility
- Voyeurism

COUNSELLING TECHNIQUES

- Setting unrealistic goals
- Not setting goals at all
- Misplacing focus in therapy
- Fostering dependency
- Emphasis on insight and neglecting behaviour change
- Making premature interpretations
- Making destructive interpretations
- Communicating beyond clients comprehension
- Rigid adherence to specific techniques

THERAPEUTIC RELATIONSHIPS

- Negative or positive countertransference
- Confrontive, authoritarian style

SECTION 3B

COUNSELLING : BASIC PRINCIPLES AND GOALS

INTRODUCTION

Counselling is a special form of interpersonal communication in which feelings, thoughts and attitudes are expressed, explored and clarified. Counselling seeks to enhance self-determination, boost self confidence, and improve family and community relationships and quality of life.

An integral part of the counselling relationship is to help people achieve the confidence to make life-style changes. This involves helping people to define for themselves the nature of the problems they are facing and then make realistic decisions about what they can do to reduce the impact of these problems on themselves and their family and friends.

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

In counselling, two people who are in no way related to each other meet to resolve a crisis, solve a problem, or make decisions involving highly personal and intimate matters and behaviours. The counsellor's emotional detachment in assessing the client's case is extremely important. There is, however, a continuous gradation between detachment and closeness, between which the counsellor must find the correct balance; this is important in promoting the well-being and problem solving skills of the client.

Counselling is both an art and a science, a "science" because of its underlying principles, an "art" because of the blend of the counsellor's personality, technique and skill. The ability to form a helping relationship is paramount in helping another individual to gain confidence and insight and it comes before techniques or technical information in one's arena of expertise.

So, in addition to technical knowledge about HIV infection, the counsellor must also build his/her self-knowledge in understanding counselling principles and values, and information about formal and informal resources. This involves assessing and knowing one's own strengths, weaknesses, prejudices and values. Many counsellors have to learn to understand their own feelings in order to be able to work with other people. Self-knowledge is particularly important when counselling people of different backgrounds or working with resistant and seemingly ungrateful clients.

Competent counsellors do not have to like all their clients, but should be keenly aware of their own reactions, feelings and prejudices and should not allow these to influence their counselling. They will also need to decide how ready they themselves are to discuss sensitive issues and to what extent their own inhibitions will complicate the counselling process.

Counsellors have their own needs and motivations, which they need to examine. They should ask themselves, for example, whether they can honestly assure other people that they will keep their secrets and maintain confidentiality. Will they be able to continue to counsel someone they dislike or whose behaviour offends them? Will they be able to use confrontation and direct guidance when necessary? Can they be accepting and keep their own prejudices in check? Will they be able to maintain professional detachment with clients who remind them of themselves or someone significant in their own lives?

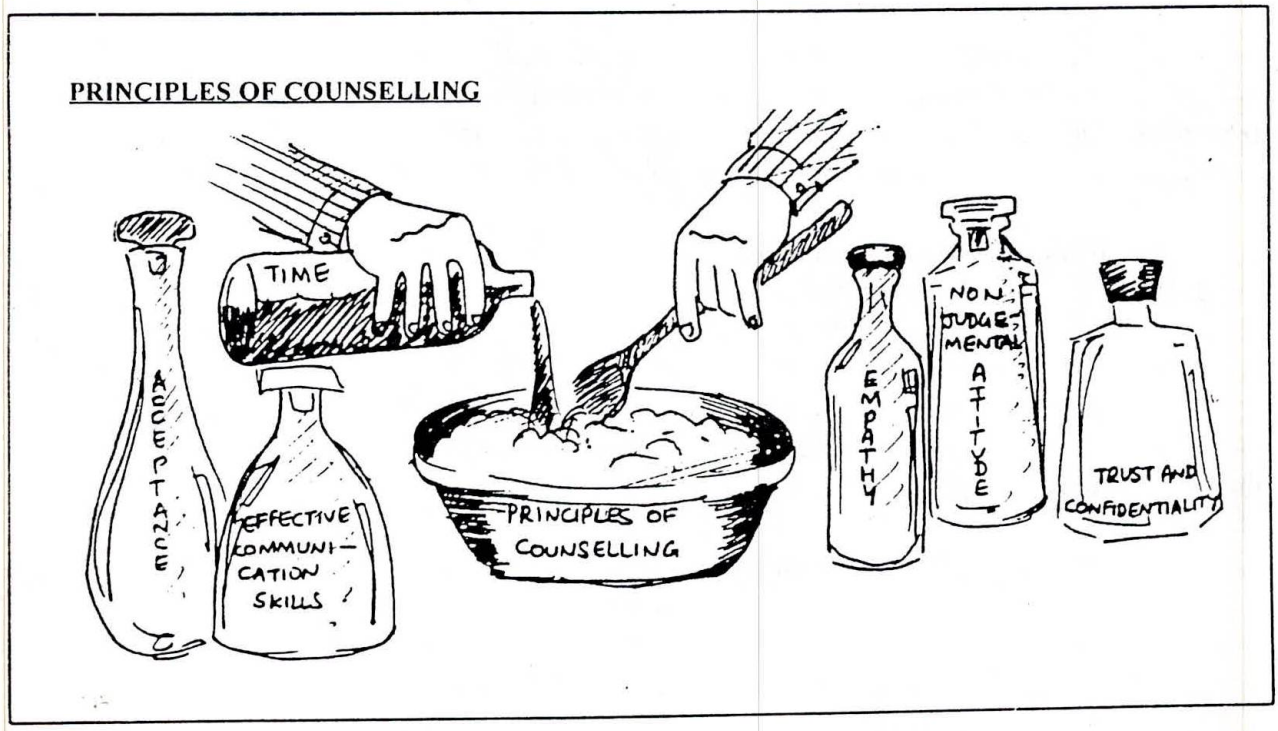
These are important questions, for the counsellor's effectiveness depends greatly on self-knowledge, self-discipline and self-restraint, and on achieving a balance between warmth and acceptance, on the one hand, and objectivity, on the other.

ESSENTIAL PRINCIPLES OF HIV/AIDS COUNSELLING

Counsellors have to pay attention to certain basic principles which keep counselling focused and directed. These are helpful in relation to HIV/AIDS as well where a counsellor works towards preventing spread of infection, helps people change their behaviour and supports people affected by HIV/AIDS

Four important principles are described below:

1. Unconditional positive regard and non-condemning attitude
2. Trust and confidentiality
3. Empathy
4. Time



1. Unconditional positive regard and non-condemning attitude

In counselling, clients are viewed as individuals with problems and given respect without judgements or condemnation of their behaviour. Unconditional positive regard relates to treating a person as special within the relationship, thus building the clients' self worth and feeling of being cared for. Counsellors must be non-condemning in their behaviour. This implies that the counsellor must not express disapproval of the person, must not apportion blame related to causes and effects of the problem of infection, or pass moral judgements that the person deserves punishment for his/her behaviour. This helps the clients feel free to talk about their problems: to feel accepted and worthy of attention.

2. Trust and Confidentiality

Trust is the basis of the relationship between the counsellor and the person/s being counselled. Trust improves the working relationship and increases the likelihood that the individual (or the group) will feel comfortable in discussing his or her problems and will act on the information provided. It is extremely important that confidentiality be guaranteed, especially in HIV/AIDS cases, due to the possibility of discrimination against, and ostracism of, an individual diagnosed as having HIV infection. The counselling relationship must be built on the understanding that whatever is discussed will remain a private issue until the client decides otherwise. Breach of confidentiality is unethical.

However, there may be some instances where the counsellor or health-care worker feels that confidentiality may need to be broken, e.g. when a client refuses to inform sexual partners of his/her infection and refuses to use any preventive methods. In this case, a decision may be made to notify the sex partners without the client's permission. Here, confidentiality is preventing the adoption of appropriate measures for avoiding the spread of HIV and so it may be necessary to reconsider the situation. In such cases, the counsellor will be required to make a decision consistent with professional ethics and relevant law and consultation with supervisors or other professional colleagues. (consensus statement from the WHO consultation on Partner Notification for Preventing HIV Transmission, WHO 1990)*.

3. Empathy and controlled emotional involvement

Empathy is more than sympathy, and it may be expressed as a statement of support (e.g. "I do understand that you are having to go through this pain"). The most basic and significant counselling skill is the ability to demonstrate empathy with the client. Empathy is the ability to understand and relate to another person's feelings and experiences. This entails being sensitive and responsive to him or her without making assumption about the client based upon what the counsellor thinks he or she would feel. A counsellor demonstrates empathy by listening attentively to what the client says, what the client does not say and what feelings the client expresses verbally or non-verbally.

The counsellor then communicates to the client his/her understanding of feelings, thoughts and attitudes regarding a particular problem. Sometimes, a gentle silence can be enough to convey empathy. To demonstrate empathy, counsellors must be acutely aware of their own feelings and responses so as to be sensitive to the client. They must be able to use their own emotional responses as clues to understanding the client while also being able to separate their emotions from their clients. The quality of empathy is something that is internalised by counsellors and then expressed on the client's behalf.

The relationship between the counsellor and the person to be counselled is not devoid of emotion and is based on warmth, concern and acceptance. At the same time, to be able to "put oneself in another persons shoes", the counsellor needs to view the situation objectively and plan realistically. Hence some level of emotional distancing or detachment is also essential, i.e controlled involvement.

Some examples of empathy Vs. Sympathy statements.

EMPATHY	SYMPATHY
1) I appreciate what you are going through.	1) Poor you! Its really sad that this should have happened to you.
2) I understand how you must be feeling.	2) I know how you feel, I was in the same situation once.
3) I can understand that you are feeling angry with your boss.	3) Your boss is really being mean and unfair to you - it is very horrible of him.
4) I accept that you are very scared and unsure if you'll be able to deal with this situation right now.	4) There, there, don't be scared! You are a strong, grown-up human being - I am behind you and will help you however I can.
5) Just sitting in silence while the patient expresses his/her sorrow by crying; it is alright to let him/ her fully feel whatever he/she is feeling and just be there with the person.	5) I am feeling very sorry for you - please don't cry - everything will be alright.

4. Time Management

Providing the client with time and recognizing that change via counselling takes time and is important from the start. Much of the content of counselling, for e.g. helping clients to absorb news about the diagnosis of AIDS, cannot be rushed. The concerns that are raised are complex and sensitive and need time to be considered and dealt with. Time is also necessary to enable rapport and trust to develop, both of which are indispensable. Some people may require many sessions before they start to acknowledge the need for examining their own attitudes/behaviours,

become open to behaviour modification and for decision-making on life-style issues. Thus time should be given at every stage to build rapport, to clarify issues, to externalize feelings, to internalize implications, to make decisions and to implement behaviour change.

GOALS OF HIV/AIDS COUNSELLING

The overall duration of counselling must be governed by the needs of the individual. Similarly, while the content of counselling may also vary, there will always be a number of goals for a counsellor to work towards in preventive and supportive HIV/AIDS counselling :

1. Forming a helping relationship

People who have just started working as counsellors often anxiously look for techniques to help them to deal effectively with other people. Techniques are helpful, but they are secondary to the ability to form a helping relationship. This is established and developed not by technique, but by the attitudes and qualities of the counsellor.

Counselling skills can be learned and effectively used only by people who are genuinely concerned about others. Concern or lack of it is conveyed both verbally and non-verbally. Unless the counsellor can demonstrate to clients a genuine concern about what is happening to them, counselling will fail.

The helping relationship and the development of counselling skills also depend on a feeling of commitment to the work to be done. Counselling in relation to HIV infection is both intensive and difficult. It requires counsellors to face their own mortality every day, to deal regularly with loss, and sometimes to accept behaviour they may find distasteful. Without commitment, a counsellor will neither be able to provide the necessary support nor work through moments of despair and stress.

A helping relationship is in some ways like a friendship, but differs in many other ways. The communication is focused and directed. There is a built-in power imbalance because the person with the problem has to ask for help, and the counsellor has the power to provide it. The counsellor makes controlled use of this power, but keeps it in check by constantly remembering and trying to imbibe the values and attitudes that are the foundations of good counselling.

As a helping relationship is formed, the counsellor should pay attention to the setting in which the client or family is interviewed. Is it at home? In a clinic office? In a hospital room? In a public place? Each of these settings will call for different responses from the counsellor. Each will influence responses from those being interviewed. A supportive, helpful relationship cannot develop if the counsellor does not acknowledge both the gravity of the problem and the context within which discussions about it take place. 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 question in private. Attention to context is important in any form of counselling, but is particularly important in counselling in relation to HIV infection because of the severe stress and stigma associated with the condition.

2. Clarifying and addressing problems

Recognizing and clarifying problems calls for sensitivity during counselling. Counselling depends on a clear definition of problems, yet counsellors sometimes neglect the client's definitions and view points. One reason may be that new counsellors feel insecure and embarrassed about asking the kinds of questions needed to clarify the client's view of the problem.

In all counselling, and especially in problem-solving counselling, the counsellor must be able to recognize the real problem. Problem recognition includes:

- defining the problem as the client sees it;
- determining why the client is seeking help now;
- ascertaining the duration and effects of the problem;
- recognizing what the problem means to, and how it will affect, the client;
- repeating to the client the counsellor's interpretation of what has been said; paraphrasing, i.e., expressing its meaning in different words; checking and clarifying to ensure that the counsellor is interpreting correctly;
- summarizing the counsellor's assessment of the problem and its effects on the client;
- finding out how the client is coping now and has coped with serious problems in the past;
- being aware of the client's feelings about the problem and about asking for help outside or from his/her circle of family and friends or from religious advisers;
- analyzing the problem in order to reduce it to manageable proportions. To the client it may appear so complicated as to be insoluble. The counsellor can show that it has a number of components or sub-problems, which can be handled separately;
- agreeing as to the problem (or part of a problem) to be tackled. This may be what the client considers most important or suitable to begin with, or what the counsellor finds most important or amenable to change.

Accurate and early identification of problems, and also putting them into a realistic time-scale, can promote self-help and coming to terms with fears and concerns about family affairs. Planning for the family, for example, in the event of chronic illness or death, is important, especially where children are involved.

It is also important to determine whether and how the client will be able to manage new information in times of physical or emotional stress. A periodic, sensitive appraisal of the person's ability to cope with the latest diagnosis and prognosis will help. It is equally important to regularly review the effect that developing physical illness may have on an individual's ability to cope emotionally and intellectually with day-to-day decisions and behaviour.

3. Establishing goals

Counselling always has a purpose. The counsellor's task is to determine what the purpose and goals are so that counsellor and client can agree on what is to be achieved, and check frequently on progress towards achieving them, or whether they need to be changed.

The goals of counselling in relation to HIV infection are necessarily governed by the chronic nature of the infection and its possibility of ending in an early death. With this reservation, counselling goals must be set which are related to what the client hopes to accomplish and what is to be expected of support systems. The goals to be achieved will depend on the nature of the problem.

Goal-setting includes:

(a) finding out how the client would like the problem to be solved;

(b) determining what the client thinks should be done to manage the problem;

(c) clarifying what the client expects from counselling;

(d) discussing what goals mean to the client;

(e) describing the help the counsellor can offer, giving realistic hope for change or assistance, and discussing the reasons for any limits on help;

(f) establishing long-term and short-term goals;

(g) stating the counsellor's commitment to working with the client.

4. Providing information on alternative resources

Any information provided through counselling (e.g. about HIV infection, risk reduction) should be consistent both in content and over time. In HIV/AIDS counselling, the counsellor therefore needs to have a clear understanding of the "facts" about HIV infection and diseases. Where clients are being seen over a period of time and as part of an integrated approach to health care, the counsellor should maintain close and confidential liaison with other health workers providing health care to that person. All counsellors should have access to updated information about HIV and its management, so that questions from clients can be answered as accurately as possible. Uncertainties must be acknowledged so that new information can be introduced in a consistent framework.

As HIV infection progresses, different medical, psychosocial, and welfare needs emerge. Information should be provided on the different types of facilities, self-help groups, community resources, and medical support that are available, as well as new changes in life-style that can be made to accommodate emerging needs. Information on alternative behaviour that includes the promotion of safer sex or avoidance of pregnancy, for example, should be accompanied by information on where to obtain condoms and on contraceptive methods.

5. Selection of realistic alternatives

Help should be given in bringing about changes in life-styles only after a review of the family background of the person concerned, including such characteristics as education, culture, religion and financial situation. Counselling should help people to select alternatives and goals that are feasible and likely to provide the personal satisfaction and support needed in adopting particular behaviours. This may involve introducing the person being counselled to groups of people who have themselves been through similar experiences, (i.e. either they or their partners are HIV-infected) particularly if they are willing to provide support, such as peer-groups of homosexual, drug-using, or heterosexual people.

6. Stimulation of motivation and decision-making

When people feel that they have greater 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. Positive encouragement of steps taken, attempts made, and a sympathetic but realistic appraisal of why they are or are not as successful as expected are important. Maintaining a respected status within the community is also likely to be a source of motivation. Explaining to clients that the actions to be taken or already attempted will help loved ones, may also be a critical source of motivation for them. The counsellor works to increase or stabilize motivation so that the stress of the discovery of having been at risk of, or of having HIV infection or AIDS, can be reduced, and a sense of control enhanced.

Supporting a client's level of motivation is a permanent feature of counselling. The counsellor must explore (and where necessary, attempt to change) attitudes which weaken motivation in the following areas:

- **The client's self-concept and self-evaluation.** Is the "self-concept" or sense of "I" one of strength or weakness? Of worthiness or unworthiness?

- **Level of self-knowledge.** How conscious are clients of their own thoughts, feelings, fears and actions?

- **Self-protection.** How do clients react to seemingly threatening information or events? Denial is a common reaction.

- **Explanation.** How do clients interpret what is happening to them and why it is happening? Is the cause seen to be within or outside the self?

- **Anticipation.** How do clients view the future? What cherished hopes or ambitions must be sacrificed?

7. Helping clients to develop competence

A key counselling skill is to help others to regain a sense of competence and skill. For example, counselling must include easy "how-to-do-it" instructions (or development of skill) on prevention of contamination and infection, use of condoms, and maintaining caring relationships during a crisis.

The counsellor must always focus on the basic behaviours needed to reduce risk of infection and protect others, and in learning how to persevere in the face of HIV infection or terminal illness. This last point is very important. It might be asked: why put so much effort into teaching people how to deal with an incurable illness? Someone who learns the skills of self-care will more readily see the need of preventive or safe behaviour and accept treatment as well as continue an active life.

Many HIV-infected people show signs of psychological distress. They may be unable to think clearly about their problems or to decide what should be done. They may withdraw socially, feel helpless and seem completely unable to make decisions or solve problems.

Counsellors working with clients to help them to re-establish their sense of competence and control must ensure that client's goals are realistic and feasible. Persons with HIV infection or AIDS will frequently fall back on a form of denial which convinces them that if they merely try harder they will recover; they therefore set too high and unattainable goals which, instead of being powerful motivators, become sources of despair.

8. Recognising and diagnosing signs of psychological distress and providing support

The counsellor must be skilled in recognizing and assessing signs of psychological distress and incapacity. Distress is a normal reaction to fearing or learning that one is HIV-infected. It can be alleviated only by expressing and discussing it, and by support. If distress persists, other, formal psychological interventions may be necessary. At times of extreme despair and anxiety, providing emotional support and reassurance should be the main focus. Helping maximize support for the client and other family members from with the family, friends and community members wherever possible must also be undertaken by the counsellor.

In summary, counselling as a process can:

(a) ensure passing-on of correct information;
(b) provide support at times of crisis;
(c) encourage change when change is needed;
(d) help clients focus and identify for themselves their immediate and long-term needs;
(e) propose realistic action suitably adapted to different clients and circumstances;
(f) assist clients to accept and act on information on health and well-being and
(g) help clients to be well-informed and to appreciate the technical, social, ethical and legal implications of HIV testing.

ROLE OF THE COUNSELLOR

In preventive and remedial therapy, in the field of HIV/AIDS, the counsellor performs certain activities which comprise of various roles. Each role is designed to achieve a certain goal. For example, the counsellor as an educator provides opportunities for learning skills and/ or information for effective role performance. Some of the roles are more directive and prescriptive (viz. pre-test/post-test and risk reduction counselling) while others, i.e. the clinical role is non-directive, reflective and process oriented. (viz. supportive counselling). HIV/AIDS counselling differs from other types of counseling or psychotherapies; in that it is essential that the counsellor educate and give specific information to the client as well as prescribe prevention behaviours.

The HIV/AIDS counsellor performs several roles depending on the nature of counselling required :

(i) Health Educator and referral - source Role
(ii) Advocacy Role
(iii) Clinical or Therapeutic Role.

The details of each role are given below.

(i) Health Educator and Referral-Source Role:

This is one of the primary roles of the HIV/AIDS counsellor to help clients function more effectively by learning new information or acquiring new social skills. The client may, for instance, learn to use the condom and practice safe sex techniques or reduce other risk behaviours. The counsellor engages in this role with a single client or groups of clients/ significant others/any other person or persons concerned with the problem.

The learning may be organized at the formal level, e.g., through workshops and training programs, or at an informal level, at the bedside of the client or with the family members during a home visit. The type of information to be given will depend on the profile of the client, his family and significant others. An illiterate client will need specific concrete information

presented in a simple, visual way (e.g. flip charts, flash cards etc.). Social skills may be learned at an individual or group level. In this role, the counsellor also recognizes the need to refer the clients to other social service agencies and institutions for alleviation of distress and achievement of life tasks. In making referrals, the counsellor provides information and prepares the client to use the other resources for e.g. refer for, HIV testing to a hospital. In case of an anxious or fearful person, support by accompanying the client or preparing a family member to accompany the client becomes necessary. The clients from low economic backgrounds could also be helped with the costs of transportation.

(ii) Advocacy Role:

This role involves securing or protecting an existing right or entitlement for one or more clients. Case advocacy is used to secure and protect entitlements of a client. Class advocacy is used to secure and protect entitlements for a group of clients that share a common status and problem.

Under the Consumer Protection Act of 1986, once a person with AIDS (PWA) approaches the hospital or health center, (s)he cannot be refused treatment. The counsellor should ensure that she/he receives prompt attention and care. Where the goals of the client and the social system are common and where minimum change is needed, strategies of problem solving, educating and persuading would be useful. For fundamental change, the counsellor needs to use negotiating and bargaining strategies as in the case of resistance in accepting seropositive persons, for care, by nursing staff who are afraid of getting infected.

However, where there is a high level of conflict and risk-taking, for instance, change in a pending Bill for mandatory testing, pressure tactics would be necessary. The latter would cover techniques such as, using the media for disclosure of the human rights problem, public and administrative hearings and, if necessary, legal action. Formation of action or task groups becomes essential when the right or entitlement affects several people together. A government ban on homosexuality, for instance, would create tremendous problems for counsellors as such harmful initiatives would force such persons to remain underground and to not seek help. The counsellor generally adopts strategies that are collaborative and least confrontational, and only later moves onto the more conflictual ones if previous methods fail.

(iii) Therapeutic or Clinical Role :

This is a major role, most often played by the HIV/AIDS counsellor with the objective of modifying attitudes, feelings, and teaching coping behaviours that affect the clients' functioning. This role is performed in agency settings or in private practice.

This role is most effective during supportive counselling for HIV infected individuals, persons with AIDS and their families. The main focus is on allowing clients to explore and express their feelings, gain insight into their inner motivations and behaviour patterns and working towards positive self-growth and effective adjustments in their relationships. The counsellor is non-directive and more focused on the empowerment of the client to make his/her own decisions and attitude shifts.

A wide variety of therapeutic approaches exist which counsellors can use for supportive counselling, depending on the specific needs and issues of each client. The main ones are : psychoanalysis, cognitive therapy and Rational Emotive Therapy, client-centered and gestalt approaches, family therapy, transactional analysis and existentialism. No matter which therapeutic approach a counsellor adopts the essential principles, goals and basic communication skills outlined in this chapter will remain the same in the context of HIV/AIDS counselling.

STAGES IN COUNSELLING

A counselling relationship with each client has a beginning, a middle and an end, and when it extends beyond just one session - contact for pre-test and post-test counselling. Even where the client and counsellor meet for only two sessions, one can structure the sessions so that there is a logical, natural progress from the beginning to the middle to the end stage. While counselling cannot be reduced to a formula, since each client is unique, certain components are universal, depending on the stage. The duration of each stage will depend on the clients' needs and readiness to move further in the counselling process.

Beginning Stage : Forming Rapport, gaining trust and defining the needs, roles and boundaries

At the beginning, clients may react in many different -sometimes contradictory ways. Although they may feel that they need help, some begin with deep distrust. They wonder whether the counsellor will like them, or may even reject them because of their condition or concerns. Some direct their anger and frustration at having risked infection or having become infected towards the counsellor, sometimes even questioning the counsellor's competence. The counsellor must accept these feelings and encourage their expression, setting limits only on verbal or physical abuse.

The counsellor should also encourage building of trust by his/her style of asking questions, particularly those about risk practices. The counsellor must explain clearly why it is necessary to inquire about intimate personal behaviour and, in the case of a reluctant client, probe the reasons for this reluctance and give realistic reassurance that the information is necessary.

Counsellors in training may find it helpful to consider counselling as story-telling. All clients have unique stories which they want to tell in their own ways. The counsellor may find the stories disjointed or rambling but must let them continue, while being objective in the assessment of the contents.

If there is hesitation or fear, gentle prompting by the counsellor is usually enough to encourage a client to continue (See also Communication Skills). Typical "prompts" include:

"And then what happened?"

"What did you feel when you were told ...?"

Such "prompts" should be used very little at first, and primarily to clarify the story. Explaining and making clear to the client the roles and boundaries of the counselling relationship is an essential part of counselling as this is a relatively new profession in India and many clients may be experiencing counselling for the first time. By de-mystifying the counselling process, counsellors help minimize whatever expectations or anxieties people may have brought with them about the process? Establishing and clarifying the client's needs and goals, with the most urgent/ important ones being addressed first, followed by the more general and long-term issues, needs to be done before ongoing counselling can begin.

As the next step in this stage, the counsellor should take a case history, in effect to help the client tell his/her story in a different, and more orderly way. The history will include basic personal data as well as information on a client's beliefs, knowledge and concern about HIV infection. With a very hesitant or anxious client, the counsellor may begin with straightforward factual questions. With clients who seem at ease or ready to talk, history-taking may begin by exploring what they know and feel about their problems. By gearing history-taking to clients' needs and readiness to discuss personal matters, the counsellor begins to establish trust and rapport with the client. History taking is a process and does not happen in one session.

The personal history obtained by the counsellor could include:

- name and other relevant personal data;
- marital status or involvement in an intimate relationship;
- number of children and where they live;
- state of health of spouse, partner, other intimate friends, children, family;
- occupation and source of income;
- recent health history;
- name of personal or family doctor or medical service;
- educational level/ability to read and write;
- name of person to contact if necessary.

While taking this history, the counsellor should note how the client speaks (shy, hesitant, direct), relates to the counsellor (looking away, angry, engaged), and whether the client finds it easy or difficult to communicate. The counsellor should aso remember that confidentiality of records needs to be maintained. Therefore, all notes and sheets related to clients should be kept under lock and key or in a safe place.

The other type of information the counsellor needs is the attitudinal and behavioural history. In this part of history-taking, the counsellor should seek answers to the following questions:

- What does the client want and expect from the counsellor and the place where counselling is done?

- What is the basis for the client's worries?

- 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 are the client's fears?
- What kinds of risk behaviour, if any, are involved?
- If there has been risk behaviour, has it been changed?
- What reactions does the client expect from others?

The counselling approach must be geared to the client's emotional state and readiness to face the facts. A factual history is usually less threatening, and a helpful entry point for assessing the client. In summary, the counsellor should use history-taking as a means of beginning to build a helpful relationship; the questions being directly related to the client's concerns and, at the same time, geared to client's needs and their ability to use the available resources.

With the information obtained in the beginning phase, the counsellor begins to work with the client to devise a plan of action. This usually concerns examining current beliefs and high-risk activities, changing behaviour and attitudes, seeking health care and building a support system.

Middle stage : Ongoing, supportive counselling.

When the client recognizes that the counsellor is available, can be trusted, will provide information, guidance and support, and will also foster independence, counselling enters the middle stage. This is concerned with refining and implementing a plan of action, which may be focused on maintaining safe behaviour to prevent infection, or to keep it limited to the client. The focus is on enabling the client to make change and move towards change. In other situations, where infection is found, discussions with the family, friends and others may be necessary regarding prevention of further transmission. Future care, financial affairs, and the needs of children and the spouse or partner may be the other issues that require to be discussed.

The most difficult and critical task at this stage is often to motivate the client to re-establish contact with the family or explain to them how the infection occurred. This process of ongoing counselling consists of supporting and sustaining work on the selected problems and monitoring the progress towards mutually decided goals. Although fear and anger are most intense in the beginning stage, they will not be fully resolved. The counsellor should support and encourage their expression in the middle stage. In case the counseller notices their absence denial and consequent inhibition of independence and decision making is indicated.

End stage : Closure or ending the counselling relationship.

As plans are developed, and carried out, the counsellor should check regularly to ensure that the client has actually performed the tasks that need to be done. Resistance to change is to be expected, exhibited by a failure to undertake agreed tasks. After the client has shown willingness to participate in formulating plans and has carried them through, counselling enters the end stage. This is often very difficult for people who have worked closely with a counsellor on intense feelings and fears. The relationship between the counsellor and client may then become correspondingly intense. Despite the need to remain objective, the counsellor may experience some feelings of attachment for the client. To the client, the counsellor may seem to be the only one who really understands and the thought of ending the counselling relationship may be painful.

For this reason, the ending must be carefully planned. The client has often suffered many losses and, although functioning adequately, he/she 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 try and be independent while knowing that the counsellor is still available. During this stage, the counsellor also needs to help the client examine the quality and strength of his/her personal support networks, encourage him/her to build a good support system among family and friends, as well as provide referrals/linkages with any self-help groups active in the city with whom the client may be able to identify. **The client must be assured of being able to return to counselling whenever this is necessary.**

The counsellor should end the relationship only when it is certain that:

(1) the client is maintaining the necessary changes in behaviour;
(2) can cope and adequately, plan for day-to-day functioning; and
(3) has a support system (family, friends, other intimates, support groups, etc.).

Tasks of the Counsellor at each stage.

In the beginning (or engagement) stage, the counsellor should:

- listen carefully and non-critically;
- respond to signs of crisis and begin helping the person to express feelings an regain control;
- explain the relevant facts about the prevention of HIV infection, the control of further transmission of HIV-infection, and AIDS;
- discuss the advantages and disadvantages of antibody testing if this is under consideration;

- whether or not the client is infected, emphasize the absolute need for behavioural change in case of high-risk behaviour;
- identify all the personal, family, social, economic and other problems that may be associated with the client's condition;
- assess the client's capacity for using information and counselling and together select problems on client and counsellor will work;
- establish short-term and long-term goals.

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

- clarify whether the client is HIV-positive or negative or whether a diagnosis of AIDS has been made and discuss related problems;
- continue to provide emotional support and act as a link to resources;
- support the continuing expression and discussion of feelings;
- help the person to move towards acceptance and control;
- make a plan of action with regard to the selected problems and goals;
- support and sustain work on the selected problems;
- monitor progress towards goals and modify them as necessary;
- promote the continuation of changes in behaviour.

Finally, in the end stage (contacts may carry on for a longer period, but with greater intervals between meetings), the counsellor should:

- prepare the client for a change in the counselling relationship;
- support the maintenance of behavioural changes;
- help to handle any continuing problems associated with the client's condition in the family or work place;
- reassure the client as to continuing interest and availability of the counsellor;
- if AIDS has developed, review plans for the management of illness, care of survivors, etc.;
- make sure that all needed and available resources (social, financial, medical) have been identified and are being used, or will be used when needed.

ACTIVITY 6: Brainstorming: What is counselling?

Time: 25 mins

Objective:

The purpose of this activity is to help trainees understand what counselling means.

Procedure:

The trainer starts the session by asking the trainees what they mean by counselling, keeping a brief note of the responses on the flipchart. Allow 10 minutes for the brainstorming.

Using these descriptions as a base, the trainer evolves an acceptable definition of counselling and puts up **OHP # 4**, to give a general definition of counselling and an introduction to HIV/AIDS counselling. He/she highlights the difference between advice-giving and counselling.

ACTIVITY 7: Presentation cum Discussion

Time: 1 hour : 30 mins

Materials: (a) OHP, transparencies and coloured markets
(b) Flip charts

Objective:

The Purpose of this activity is to help the trainees understand the principles and goals of HIV/AIDS counselling, as well as the role of the counsellor. Every counsellor interaction is based on certain principles of counselling. In HIV/AIDS counselling, the principles of acceptance, non-condemning attitude and confidentiality are very essential to the establishment of a trusting rapport and relationship with the affected person/s/groups. In this activity, we will learn in detail the principles which are pre-requisite to any counselling process.

Procedure:

The facilitator should discuss the essential principles of HIV/AIDS counselling in detail. With each principle, give an illustration. For instance, while using **OHP # 5** point out that if a nurse responds to a patient by saying "I am so sorry that you are feeling like this, but what can I tell you?" ask the trainees to answer whether this sentence conveys sympathy and empathy.

Next, go over the goals of HIV/AIDS counselling and the role of the counsellor with the help of **OHP # 6**. Encourage the trainees to ask questions throughout the presentation. Use a flip chart to maintain a 'PENDING TRAY' of issues arising from the questions. Finally present **OHP # 7** to illustrate the three stages in counselling. Conduct a brief discussion on how the counselling relationship is initiated between a counsellor and a client, the various stages that follow and how various communication skills (previously covered in this module) are important and useful at each stage. During this discussion, it needs to be emphasized that time and attention should be given to each stage in the order that it occurs, so that the client understands what the goals are at each stage. In the last 20 minutes, take up the issues in the 'pending tray' for discussion. If the trainer is unable to complete, prioritize with the trainees and leave the rest for the next session as there may be similar issues when discussing the process and techniques of HIV/AIDS counselling.

OHP # 4

COUNSELLING IS A SPECIAL FORM OF INTERPERSONAL COMMUNICATION IN WHICH FEELINGS, THOUGHTS AND ATTITUDES ARE EXPRESSED, EXPLORED AND CLARIFIED.

HIV/AIDS COUNSELLING HAS TWO GENERAL OBJECTIVES:

(1) **To prevent HIV infection by advocating and motivating behaviour changes and lifestyle changes.**

(2) **To provide psychosocial support to those already infected/affected by HIV/AIDS.**

OHP # 5

ESSENTIAL PRINCIPLES OF HIV/AIDS COUNSELLING

1. **Unconditional positive regard and non-condemning attitude**
2. **Trust and confidentiality**
3. **Empathy and controlled emotional involvement**
4. **Time management**

OHP # 6

GOALS OF HIV/AIDS COUNSELLING

These will vary, but they include:

1. **Forming a helping relationship.**
2. **Clarifying and addressing problems.**
3. **Establishing goals.**
4. **Providing information on alternative resources.**
5. **Selection of realistic alternatives.**
6. **Stimulation of motivation and decision-making.**
7. **Helping clients to develop competence.**
8. **Recognizing/diagnosing signs of psychological distress and providing support.**

OHP # 7

STAGES IN COUNSELLING

1. **BEGINNING STAGE - Forming rapport, gaining trust, definition and understanding of roles, boundaries and needs.**

2. **MIDDLE STAGE - Ongoing, supportive counselling and goal setting.**

3. **END STAGE - Closure or ending the counselling relationship.**

SECTION 3C

HIV/AIDS PREVENTIVE AND SUPPORTIVE COUNSELLING : OBJECTIVES AND METHODOLOGY

PREVENTIVE COUNSELLING : RISK REDUCTION , PRE-TEST AND POST-TEST COUNSELLING

Introduction:

HIV/AIDS counselling has two general objectives:

(1) to prevent HIV infection and its transmission to other people;
(2) to provide psychosocial support to those already infected/affected.

In order to prevent HIV infection, the chief features of counselling that come to the forefront are risk-assessment, risk-reduction and pre-test/post-test counselling. Supportive counselling and crisis counselling are the main approaches used when providing support to HIV/AIDS infected persons and their families.

Keeping these two broad categories of HIV/AIDS counselling in mind, one can clearly see that counselling would be recommended for the following people/cases :

- Those seeking help because of past or current risk behaviour and have heard about HIV/AIDS;
- Those being tested for HIV (pre-testing and post-testing);
- Those not seeking help but practicing high risk behaviour;
- Persons already identified/diagnosed as having AIDS or being infected with HIV, and their families or significant partners.

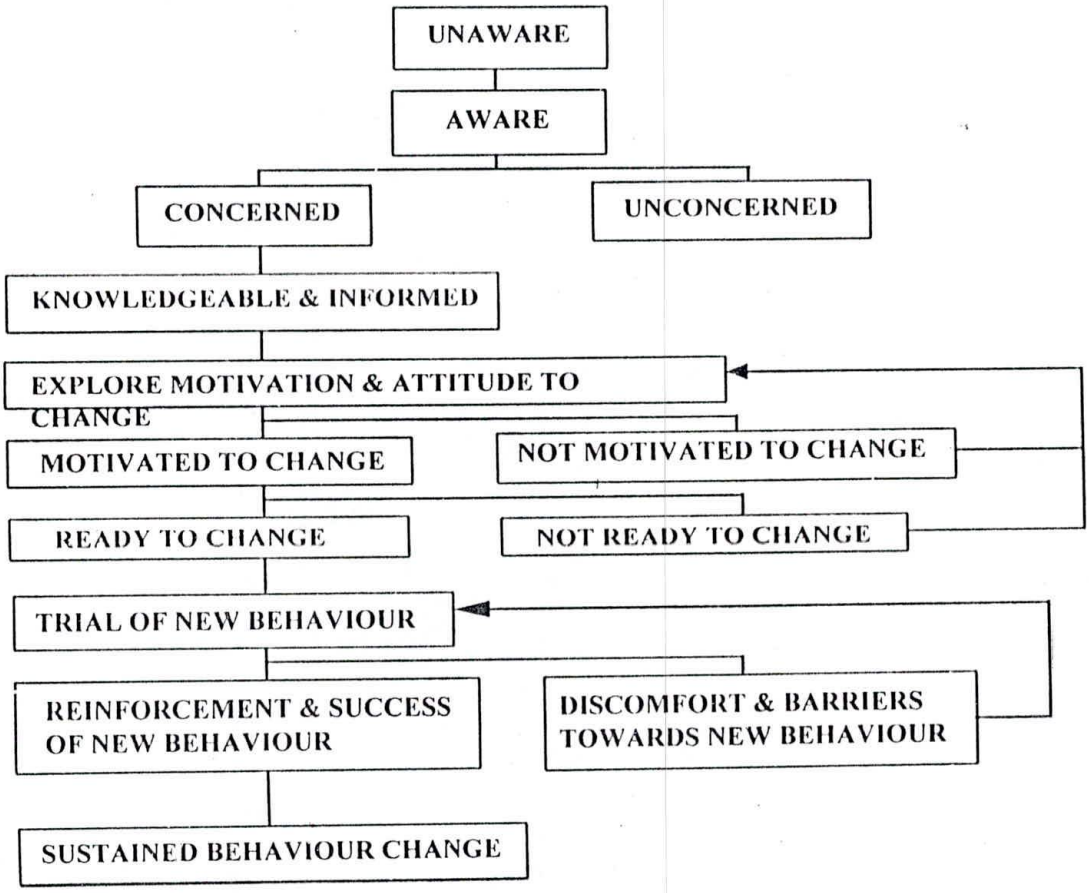
HIV/AIDS counsellors play a key role in helping individuals assess their risk of HIV infection and bring about risk reducing behavioural changes. This should take place across the country, irrespective of whether facilities for testing exist or not. In a developing country like India, it will take a long time before opportunities for voluntary testing can be made available. It will take even longer for the common man to become aware of the need to utilize it even when available. It is therefore imperative that wherever possible, people with basic counselling skills are available to counsel and evaluate those at risk and counsel them towards safer behaviour

In order to prevent the rapid spread of the HIV/AIDS epidemic, it is essential that there be adequate dissemination of information related to HIV/AIDS in the community. However, it is also seen over and over again that information per se does not lead to behaviour change. Hence it is important that a large group of workers from varying sections of society (Health personnel, teachers, social workers etc.) use basic counselling skills to help people identify their own risk and appropriately change behaviour. This should also take place during pre-test and post-test counselling sessions.

The flow of behaviour change proceeds like this :

Information/Education → Attitude change → Behaviour change

While doing risk assessment, risk reduction or pre-test/post-test counselling, the counsellor should keep in mind the natural stages the client's thinking and reactions will go through before behaviour is changed. These are :



Risk assessment and risk-reduction counselling

Risk assessment and risk reduction counselling is an interactive process between counsellors and clients in which counsellors function more as health educators who provide clear and simple information, clarify misinformation, and assist in decision-making and implementation of behavioural changes. Due to the intimate, and often taboo, nature of risk behaviours, counsellors need opportunities to practice asking explicit questions about sexual and drug use matters while noting their own reactions, values and attitudes, so that they become comfortable in talking to clients about these issues.

The process of risk assessment involves bringing a person to the understanding that HIV poses a personal threat as a result of his or her behaviour. Education with counselling can help people break through their denial and come to terms with their potential risk. In this context, counselling is directive and information-oriented.

The counsellor assists the individual to recognize that, although HIV is a personal threat, it can be avoided by adopting safer behaviours. Once this message is internalized, the counsellor helps the client decide which behavioural changes are needed and how to implement them.

HIV/AIDS counsellors face considerable challenges in helping people to assess their risk and reach decisions about the changes they are willing to make to reduce it. Changing sexual and drug use practices, even in the face of danger, is no easy task.

The goals of a risk assessment counselling session are to help the client:

- Personalize his or her risk of HIV infection by recognizing that it is a personal threat.
- Assess his or her current and past risk of HIV infection.

At the beginning of the counselling session, it is important to discuss the following:

- Discuss the importance of assessing the risk of getting HIV so that the disease can be prevented. Explain that in order to do this, explicit sexual behaviour and substance use, including behaviours which may be culturally considered subjects taboo subjects must be discussed. Explain that the purpose is not to make assumptions about or judge a person's behaviour but rather to prevent the person becoming sick or transmitting HIV to others.
- Explain the necessity of reviewing all forms of risk behaviour with each individual.
- Explain the specific area for HIV risk assessment (Table 3 below).

TABLE 3

Assessment of Risk

1. Frequency and type of sexual behaviour and specific practices; in particular, high-risk practices, such as vaginal and anal intercourse without using condoms, unprotected sexual relations with prostitutes, and drug injecting individuals.
2. Being part of a group with known HIV prevalence or with known high-risk life-styles, e.g., injecting drug users, male and female prostitutes and their clients, prisoners, homosexual and bisexual men.
3. History of blood transfusion, organ transplant, or administration of blood or body products.
4. Exposure to possibly non-sterile invasive procedures, such as tattooing and ear piercing.

- Assess the client's knowledge of how HIV is transmitted and clarify any misinformation.
- Ask the client to assess his or her current and/or past high risk behaviours.
- Ask the client to assess his or her risk of HIV infection. Discuss any concerns and clarify misconceptions.
- Summarize the discussion about the client's risk of HIV infection, leading to discussion about risk reduction.
- Acknowledge the discomfort and embarrassment the client may feel in discussing explicit sexual behaviour and substance use openly. Reassure them that these are normal reactions.
- Explain that the client will be asked to reveal very personal and explicit information that is not normally discussed with others, and that confidentiality will be maintained.

It is difficult to clearly separate risk assessment and risk reduction as the first spontaneously flows into the second. In effect, risk reduction counselling carries forward the process begun by a risk assessment session to the next stage.

The chief points to cover while talking about risk reduction:

- Recognize that HIV transmission is avoidable.
- Identify behaviour changes that will reduce the client's level of risk of contracting or transmitting HIV.
- Plan behaviour changes. Changing sexual and drug use behaviours is difficult: these are step-by-step changes which take time, effort and commitment.
- Develop strategies to overcome potential obstacles in implementing and sustaining new behaviours.
- Evaluate the success and reinforce positive changes. If the client is available for follow up, it is worthwhile to see how much change has occurred and encourage the positive action that has taken place.

PRE-TEST AND POST-TEST COUNSELLING

Testing raises many questions for the counsellor, the most basic being, how to assess the client's reasons and motivation for seeking a test. People sometimes donate blood so as to have an excuse for undergoing an antibody test. The counsellor should discourage this practice. Those who do so, miss the opportunity which counselling offers to discuss safe sexual practices and related matters.

In some places facilities for testing are not readily available. Where this is so, every effort should be made to emphasize preventive counselling, especially the need for behavioural change where there has been high-risk activity, and the maintaining of low-risk behaviour where behaviour change has been practiced. Counselling, education, information, and support are all vitally important in bringing about and maintaining behavioural change.

Both the pre-test and post-test counselling sessions should accompany testing - or the decision not to be tested. The information given at these sessions can be reinforced by providing written material.

However, in reality, no pre-test counselling is usually provided and the first contact a counsellor has with a client is after the test has been done and the result handed over to the counsellor. Thus, it becomes necessary for the counsellor to cover the main issues of pre-test counselling (See Table 2) before disclosing the test result and dealing with the client's reactions. The post-test counselling session becomes very crucial and the counsellor should do some prior preparation and planning before such a session. He/she would also have to be ready for any strong, emotional reactions (like anger) that the client may have about the whole testing process or about not having been given support or adequate information prior to the testing.

Counsellors often have to deal with wrong ideas and even anxieties about HIV antibody testintg. The counsellor needs to inquire about the testing procedure followed for each case and he/she needs to know that a single test or screening does not make a person positive - confirmation tests must be done before a diagnosis is made. The counsellor must ensure that the client understands what the test implies and what a positive or negative result means. Many people believe that a positive enzyme-linked immunosorbent assay (ELISA) means that they have AIDS, and this may cause great distress. The counsellor must deal with the fear and set out the facts unambiguously. People whose test is negative may feel relieved and believe that they can go on living again in the same way as before. Preventive counselling must begin immediately. They must be told about the "window period" and what they should do to prevent acquiring or passing on the infection, and be urged to return for follow-up counselling.

Pre-test counselling

Ideally, rapport and contact should be established between the counsellor and the client prior to testing and the same counsellor should see the client before and after testing. Counselling before the test should provide individuals who are considering being or being recommended to be tested with the information on the technical aspects of screening and on the possible personal, medical, social, psychological, and legal implications of being found either HIV-positive or HIV-negative. The information should be given in a manner that is easy to understand and should be up to date.

A decision to be tested should be an informed decision. Informed consent implies awareness of the possible implications of a test result. In some countries, the law requires explicit informed consent before testing can take place; in others, implicit consent is assumed whenever people seek health care. There must be a clear understanding of the policy on consent in every instance, and anyone considering being tested should understand the limits and potential consequences of testing (analysis of legal and ethical issues in the Indian context, is given in section 3D of this module).

Testing of HIV infection should be organized in a way that minimizes the possibility of information disclosure or of discrimination. In screening, the rights of the individual must also be recognized and respected. Counselling should actively endorse and encourage those rights, both for those being tested and those with access to records and results. **Confidentiality** should be ensured in every instance.

Issues covered in pre-test counselling

Pretest counselling is done in addition to giving preventive information and is centered on **two main topics**: first, the person's history and risk of being or having been exposed to HIV; secondly, the client's understanding of HIV/AIDS and previous experience in dealing with crisis situations.

The issues and questions involved in such assessments are presented below:

Table 2

Questions on Psychosocial Factors and Knowledge for Pre-test counselling

1. Why is the test being requested?
2. What particular behaviours or symptoms are of concern to the client?
3. Has the client sought testing before and, if so, when, from whom, for what reason, and with what result?
4. What does the client know about the test and its uses?
5. What are the client's beliefs and knowledge about HIV transmission and its relationship to risk behaviour?
6. Has the client considered what to do or how he/she would react if the result were positive, or if it were negative?
7. Who could provide (and is currently providing) emotional and social support (family, friends, others)?

Pre-test counselling should include a careful consideration of the person's ability to cope with a diagnosis and the changes that may need to be made in response to it. It should also encourage the person being counselled to consider why he or she wishes to be tested and what purpose the test will serve. When the counsellor enquires about personal history, it is important to remember that the client:

- may be too anxious to fully absorb what the counsellor says;
- may have unrealistic expectations about the test;
- may not realize why questions are being asked about private matters and therefore be reluctant to answer; and
- may not be willing to change behaviour irrespective of the result.

The initial assessment should make it possible to discuss and assess the likelihood of the client understanding the following: (a) the meaning and potential consequences of a positive or negative results; and (b) how change in behaviour can reduce the risk of infection or transmission to others.

During pre-test counselling, it is also important that the client be told that current testing procedures are not infallible. Both false-positive and false-negative results occasionally occur, although supplemental (confirmatory) tests are very reliable if an initial test is positive. These facts must be clearly explained, together with information about the "window period" during which the test may be unable to assess the true infection status of the person. It should also be made clear that no test can tell whether someone has, or will, develop AIDS and the presence of HIV antibodies in the blood is proof only of HIV infection.

In summary, pre-test counselling should:

- determine what the client understands about HIV and AIDS;
- provide factual information as needed;
- discuss potential implication of a positive and negative test result;
- explain and obtain informed consent;
- review the test procedure;
- assess the person's ability to cope with a positive result, and
- establish who else should be informed and is likely to be supportive to the client if tested positive.
- establish a relationship as a basis for post-test counselling.
- provide adequate preventive counselling.

Once a decision has been made to take the test for HIV antibody, arrangements should be made to schedule a post-test counselling session.

Post-test counselling

The post-test counselling session is mainly designed to help the client :

- Cope with the immediate reactions to the test result (ranging from indifference to relief to denial and shock)
- Integrate and understand the meaning of the test result at all levels (rationally, emotionally, behaviourally, medically).
- Develop a health plan for risk reduction.
- Maximize healthy coping skills and strategies.

HIV testing can have three possible outcomes:

(a) a negative result;
(b) a positive result;
(c) an equivocal result.

PSYCHOLOGICAL REACTIONS AFTER A POSITIVE HIV TEST

(a) Counselling after a negative result

It is very important to carefully discuss the meaning of a negative result (whether this was expected or not). The news that the result was negative is likely to produce a feeling of relief or euphoria, but the following points must be emphasized:

1. Following possible exposure to HIV, the "window period" needs to have elapsed before test results can be considered reliable. This means that, in most cases, a minimum of at least three months must have elapsed from the time of possible exposure before a negative test can be considered to mean that infection did not occur. A negative test result carries greatest certainty if at least six months have elapsed since the last possible exposure.

2. Further exposure to HIV infection can be prevented only by avoiding high-risk behaviours. Safer sex and avoidance of needle-sharing must be fully explained in a way that it is understood and permits appropriate choices to be made. (i.e. risk reduction counselling)

3. Some clients have a false belief that since high risk behaviour has not led to infection so far, they have a natural "immunity to HIV". This should be addressed or else the motivation to change behaviour will be low. In some cases, when a client has an infected spouse/sex partner whom he or she identifies with, a negative result may be seen as a failure and may increase the client's risk behaviour in an attempt to get infected also. This kind of motivation also has to be kept in mind.,

4. Other information on control and avoidance of HIV infection, including the development of positive health behaviours, must be provided. It may be necessary to repeat such explanations. The counsellor and the person being counselled may need to practice together methods of negotiating these with others in order to assist the client in introducing and maintaining the new behaviour.

The procedure for disclosing negative test results is :

(i) Establish rapport with the client.
(ii) Disclose test result.
(iii) Assess :

- ❍ the need for a re-test if there have been potential risk factors in the previous six months;
- ❍ the client's commitment to continue his negative status;
- ❍ the client's alcohol and drug use (which could impair judgement and/or lessen commitment to safer sex practices).

(iv) Provide information on risk reduction, viz. non-penetrative sex options, proper condom use and needle cleaning.
(v) Develop a health plan for risk reduction, setting specific and realistic goals.
(vi) Provide resources and referrals as needed or requested.

(b) Counselling after a positive result

People diagnosed as having HIV infection should be told as soon as possible. The first discussion should be held in private and under conditions of confidentiality, and 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 this news means. This is not a time for speculation about prognoses or estimates of time left to live, but for acknowledging the shock of the diagnosis and for offering and providing emotional support. It is also a time for encouraging hope - hope that achievable solutions can be found for resulting personal and practical problems.

After a positive result the counselling relationship may enter a new phase. Crisis counselling will always be necessary as the first step. The pre-test assessment can be reviewed to determine the best way to tell the client about the test result. How the news is accepted will depend on the person's personality, psychosocial circumstances, education level, previous knowledge of HIV, and cultural attitudes towards AIDS. The client must be told how he/she can 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. In India, where societal approval and other people's opinions are very important in influencing one's behaviour, it will be necessary to focus on and deal with the client's anxiety and apprehensions about others getting to know the diagnosis. All the information previously given about safer sex, prevention of transmission, and maintaining health must be repeated. Follow-up visits must be arranged, often on a routine basis.

Counsellors must always stress the individual's responsibility for changing behaviour to avoid re-infection, or to limit, if not eliminate, the risk of transmission to others. They must also emphasise the life-long nature of the infection.

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

1. The person's **physical health** at that time. People who are ill may have a delayed reaction. Their true response may appear only when they have grown physically stronger.

2. How **well prepared** the person was for the news. People who are completely unprepared may react very differently from those who were prepared and perhaps expecting the result. A previous session of pre-test counselling would increase a person's preparedness. However, even those who are well prepared may experience the reactions described herein.

3. How **well supported** the person is in the community and how easily he or she can call on friends. Factors such as education level, employment, job satisfaction, family life and cohesion, and opportunities for recreation and sexual contact may all make a difference in the way a person responds. The reaction to the news of HIV infection may be much worse in people who are socially isolated, have little money, poor work prospects, little family support, and inadequate housing.

4. The person's **pre-test personality and psychological condition**. Where psychological distress or depression existed before the test result was known, the reactions may require different case management strategies. Post-result management should take account of the person's psychological and/or psychiatric history, particularly as the stress of living with HIV may act as a catalyst for the reappearance of earlier disturbances.

In some cases, news of HIV infection can bring out previously unresolved fears and problems. These can often complicate the process of acceptance and adjustment and will need to be handled sensitively, carefully, and as soon as possible.

5. The **cultural and spiritual values attached to AIDS, illness, and death**. In some communities with a strong belief in life after death, or with a fatalistic attitude towards life, personal knowledge of HIV infection may be received more calmly than in others. However, there may also be a sense of helplessness and hopelessness. On the other hand, there may be communities in which AIDS is seen as evidence of antisocial or blasphemous behaviour and is thus associated with feelings of guilt and rejection.

Counselling and support are most needed when reactions to the news of HIV infection appear. Some reactions may initially be very intense and may even be suicidally oriented. It is important to remember that such responses are a normal reaction to life-threatening news and as such should be anticipated. However, they should be taken seriously and time should be spent in assessing the gravity of any suicidal impulses or depression in the client. The client should be suitably counselled to alleviate such emotions.

The first reaction is likely to be a state of shock or denial. Following this, some people feel emotionally overwhelmed and experience a feeling of loss of control or helplessness; this may be exhibited as a flood/outpouring of emotions, thoughts and questions. Other reactions which may be expressed are : depression, guilt, self-blame, anger, fear and suicidal thinking. The counsellor should support the client by helping to contain the anxiety and providing reassurance that his/her feelings, concerns and decisions will be dealt with during the counselling process.

The procedure for disclosing positive test results is :

(i) Establish rapport with the client.
(ii) Ask if there are any questions.
(iii) Follow the lead of the client as to when to disclose the results (except where the client is very impatient and wants to know only the result without understanding what the test is for or the meaning of HIV/AIDS).
(iv) Give the test results in a direct, neutral, non-judgemental tone.
(v) Wait for client's responses before answering or continuing with the session.

The following points need to be repeatedly emphasized:

1. HIV infection is not AIDS. Prognoses vary, but every infected person should be encouraged to live a normal social and economic life unless AIDS-related symptoms do not permit this. Since normal living requires the support of others, those concerned may need to be informed and also provided regular counselling to anticipate and cope with new needs.

2. A person who is HIV positive should take care of his or her general health. The presence of other infections, such as other sexually transmitted diseases will affect the immune system's response and may hasten the development of AIDS. The counsellor must stress the need to avoid exposure to illness as a measure to prolong life. The counsellor must explain how the infections can be avoided through general home hygiene. The prevention of other sexually transmitted diseases by the use of condoms and by reducing the number of sexual partners should also be explained.

3. Spouses and partners will need support; telling them that the test for HIV infection has been found positive is difficult, and considerable support may be needed from the counsellor. Bringing spouses or partners in for counselling to prevent transmission, and where indicated, testing, is a frequent counselling goal.

4. Spouses and partners must be protected against infection: Condoms should be recommended to prevent infection/ transmission and re-infection of the patient. The counsellor should stress the need for care in ensuring that the condoms are of good quality. The counsellor should also demonstrate the correct usage of condoms. The use of condoms may not be acceptable in some cultures. Objections to them, and the consequences of not using them, need to be discussed.

INCLUDE SPOUSES DURING COUNSELLING

In summary, post-test counselling in case of a positive result should:

- ensure that the person understands what a positive HIV test result means;
- discuss how they feel 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;
- counsel partner(s) if possible. and
- refer the person to local community services and existing support networks, if possible.

(c) Counselling after an equivocal test result

A test result may be equivocal for a number of reasons: for instance, there may have been insufficient time for full seroconversion to take place since the possible exposure to HIV occurred (the "window period" previously mentioned). In such circumstances, there are two main issues for the counsellors to deal with:

1. **The test used to determine whether the person is infected with HIV**. The first tests most commonly used are ELISA or spot tests. Since ELISA has levels of sensitivity approaching 99.5%, a negative result can be regarded as a definite indicator that the person is not infected, except for tests carried out during the

"window period". Correspondingly, a positive result suggests the possibility of HIV infection. The usual procedure then is to retest, using ELISA or 2 spot tests. If this test is repeatedly positive, supplemental or confirmatory testing may be required, using for instance the Western Blot Test. However, a lot of centres today are diagnosing on the basis of ELISA and spot tests only as these are considered acceptable by medical experts. The result of such supplemental testing can either be positive, strongly indicating HIV infection; negative, indicating no infection; or indeterminate. An "intermediate" result of supplemental testing (and it may be in up to 10% of samples in some areas), may be for the following reasons:

- the person has developed non-clinical signs of HIV infection more quickly than might normally be expected;
- a related HIV virus is present;
- a cross-reaction is occurring with a non-viral protein and the reaction is simulating part of an HIV related protein;

The following options are then available:

- to use alternative methods with the aim of obtaining a reliable result, e.g. by using combinations of techniques so as to exclude false-positive results;
- not to carry out further testing. Where the result is indeterminate and either the results of further testing are being awaited or further testing is not possible, it is not possible to say with any degree of assurance that the person is HIV-infected. The counsellor should then advise the person to present himself/herself after three months for repeat testing. It is important to remember that, in areas with low levels of HIV infection the probability of finding a false-positive result is greater than in those where background rate of HIV infection is high. Thus, in communities where many people suffer from AIDS, it is more likely that a positive ELISA result is accurate.

2. **Prevention counselling and support while waiting for an unequivocal result.** The period of uncertainty following an initial equivocal or indeterminate test results may be three months or longer after the last instance of potentially high-risk exposure or the previous test of HIV infection. It is then important for counsellors to emphasize essential prevention messages regarding sexual and IV drug-use activity, body fluid and tissue donation, and breast-feeding. The person will need to undertake the precautions recommended for HIV positive persons until proven otherwise. Further the uncertainties associated with this period may lead to acute and severe psychosocial difficulties, and the counsellor must be prepared to assess and manage such issues or to make appropriate referrals, if necessary, in every case.

CRISIS COUNSELLING

In HIV/AIDS situations multiple crisis could occur. The news that a client is HIV infected can be a crisis for him/her, creating stress, evoking cognitive (thinking), intense affective (emotional) and behavioural responses.

A 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
- emotionally paralysed as 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.

The individual usually goes through **four stages** of the crisis: **the blow, the recoil, withdrawl, and acceptance**.

The **blow** is the shock of fearing or realizing that something is wrong - a symptom appears, or there is 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 implication of the crisis. In this process, the person may deny and recoil from the news (the new reality) and demand a battery of tests in another clinic.

Many **withdraw** in order to be alone with their sorrow or anger, and isolate themselves.

Some people can quickly begin to come to terms with **(accept)**, and adapt themselves to their predicament.

Reactions to fear of being HIV-infected or confirmation of infection or of AIDS in the crisis mode may include:

- Denial (This can't be true)
- Anger (Why me? What did I do to deserve this?)
- Bargaining (God, if you let me off now, I will...)
- Resignation (I am helpless...)
- Acceptance (I will do my best as long as I can).
- Fatalism (This was meant to be .... its my destiny..)

Not everyone will display these reactions, but most will to some degree.

Once the crisis stage is over the fact of being seropositive continues to create stress in the individual if not adequately supported. However, all seropositive persons do not respond in the same way. A person may show greater capacity to adapt and to continue a productive life while another person may go into depression. The counsellor must be able to recognize the variability across individuals and tolerate uncertainty when making predictions about the possible effects of stress.

When a client is in a crisis state, a counsellor does not say: "You are over-reacting", but instead listens carefully and comments on the strength of the feelings and the fear, or on the client's efforts to deal with the problem.

What is important is that the counsellor should respect the client's perception of crisis, and go on from there.

Crisis counselling is designed to help the client cope with and resolve the crisis. The counsellor does not panic, offer false assurance, give advice, or take offence. The counsellor offers:

- *Acceptance. (Example: "You are angry at yourself, at me, and everyone else".)*
- *Emotional support. (Example: "You are very frightened and you may need some extra time to talk. I shall be here.")*
- *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.")*

Some basic principles of counselling in crisis are:

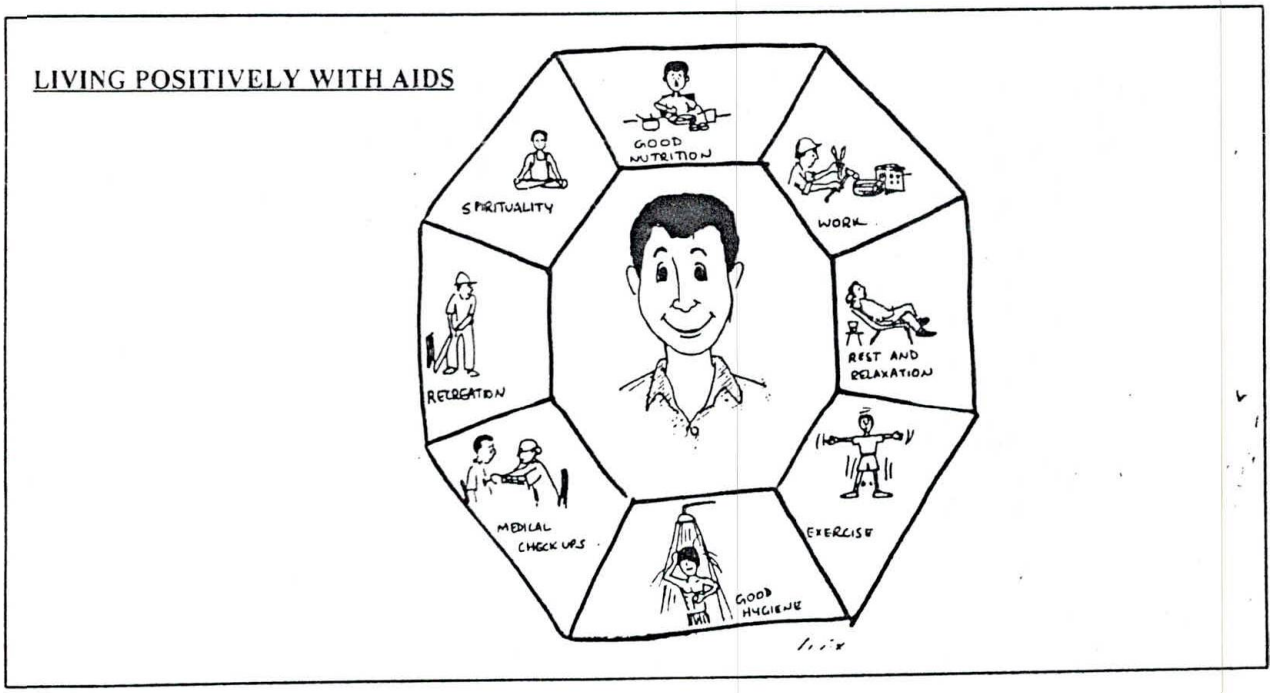
(i) Stay in the "here and now", i.e., focus on the client's expression of feelings and anxieties. It is not the time to talk about past history or behaviour, but about present feelings.
(ii) Clarify what the client regards as the crisis.
(iii) Determine the client's feelings about the event or information.
(iv) Check and attempt to reduce feelings of helplessness, hopelessness, and loss of control by means of questions and observations.
(v) Give a brief assessment of the position and show that the seriousness of the crisis is appreciated.
(vi) Ascertain what the client regards as the most, as well as the least threatening, aspect of the crisis.
(vii) Select one aspect on which to begin work, preferably involving a task that the client can accomplish with least support.
(viii) Agree on what is to be done to resolve or ease the crisis.
(ix) If the client is using denial as a defence mechanism or is too distressed to understand what is being said give some information repeatedly.

It would be useful to suggest to the client methods which would enhance his/her coping skills. Various techniques are available, and it would be useful for the counsellor to be aware of some of these. One method which could be easily learnt is relaxation. A basic form of the relaxation method is to close one's eyes and concentrate on one's breathing, while letting one's body loose and relaxed. This should be practiced for 15 minutes, twice daily in a quiet place. Any thought or intruding worries should be removed and not allowed to interrupt the exercise, i.e. attempt to free the mind of thoughts and messages for those 15 minutes.

SUPPORTIVE COUNSELLING

HIV/AIDS counselling involves, on the one hand, helping persons with HIV/AIDS to lead active, productive and hopeful lives to the extent possible and, on the other, to cope with the probability of shortened life expectancy. During periods of relative health, issues involving activities and personal goals are important. The counsellor helps the client to maintain hope and engage in constructive life patterns. During other periods, coping with the prospect of death is a more salient issue.

The stress of having HIV infection may precipitate stressors in other aspects of life viz. relationships with family members, with friends and in the workplace. Sometimes, having to hide the knowledge of being infected creates inner tension and isolation. A child may face rejection in school due to his/her illness or his/her parents HIV-positive status and develop behavioural problems at home. HIV-infected clients often get minor illnesses (unrelated to HIV/AIDS). This can induce a crisis particularly if the client takes it to mean that he/she has developed AIDS. The counsellor thus needs to examine various areas of social functioning to have a complete picture of the stress effects of HIV/AIDS on the individual, family and related groups. A proper assessment of the source of the stress will help the counsellor plan realistically to reduce stress and increase the coping skills of the client(s).



The family is a very important social system in the Indian context and performs very essential functions ranging from socialization to providing the basic means for survival. Despite some level of social change in the urban areas, the family continues to be a dependable support system for a sick person. Hence, the elders, the spouse and 'significant others' need to be considered as an important resource.

There are practical reasons for informing the family and close associates; they will be called upon to provide care and support, and their own interests must be considered, especially when children are involved. The counsellor may need to be present when family members and others are being informed of the clients HIV status.

Many people will be reluctant to disclose the fact for feelings of shame and guilt, and for fear of being rejected, or ostracized. The counsellor must accept that such fears are understandable but, nevertheless, encourage the clients to re-examine their objections to disclosure. The counsellor must also encourage the client to look to the family or other close associates for support. 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, as well as rehearse the process of informing the family.

In the end stages of HIV-related diseases and AIDS, the counsellor's role is primarily supportive. The counsellor should be familiar with the common stages of death and dying (Kubler-Ross, 1969). Disbelief or denial, anger, depression, 'bargaining', and acceptance are common psychological reactions to the threat of death. Some of the useful techniques identified in helping deal with the diagnosis and HIV/AIDS infection are as follows:

1. *Keep it simple. The counsellor is likely to feel very anxious about dealing with the terminally ill AIDS clients.* This may lead to over talkativeness, use of confusing language or jargon, jitteriness, stiff body posture, or failure to give the client adequate opportunity to talk or ask questions. The counsellor must be aware of his/her own anxiety and handle it by discussing with another colleague and/or adopting relaxation techniques.

2. *Wait for questions. The counsellor can use silence effectively and provide the client an opportunity to express his/her feelings.* The counsellor can wait for questions to arise. All questions need not be answered. The client may be expressing emotions through questions (Why is it happening to me?). The underlying emotions can then be acknowledged and allowed expression.

3. *Find out what the diagnosis means to the client.* The counsellor needs to understand how the diagnosis and infection is affecting the client through questioning and observation of the client's interpretation and personal meanings attached to the diagnosis. The counsellor corrects misconceptions and answers questions in a supportive environment, thus conveying that (s)he is knowledgeable and can help.

4. *Don't feel that you have to answer at one time every question that could arise.* The counsellor must give the client time to absorb, think and reflect over the information which should be given in bits and pieces over several visits.

5. *Don't argue with denial* : If the client wants or needs to deny the information offered, respect his/her right to do so; avoid confrontation. As trust and confidence in the counsellor grows, openness and communication from the client will also increase. An initial sense of being accepted is very important to build a strong client-counsellor relationship.

6. *Check for understanding.* After you have provided some information, check whether the client has understood the information.

7. *Leave room for hope but do not lie.* The counsellor should let hope live without being untruthful to the client. The counsellor should make himself comfortable about handling questions like, 'Is this AIDS?','Am I going to die?'

8. *Support or facilitate discussion on plans for the family.* The counsellor should help the client to organize legal and income matters for ensuring security for the spouse/ family. In case of breadwinners from the poverty groups, the counsellor may have to assure the client of mobilizing support for his spouse/ family in terms of short-term relief and long-term alternatives for employment, etc. Such planning will help the client to reduce his anxiety about his impending death as well as encourage cognitive coping through a reality orientation approach.

9. *Encourage use of rituals and cultural practices to help face the illness and death.* With the help of the family priest or elders which involves administering of traditional rites and sacraments of faith or religion, the counsellor can provide support and counselling and help the client to use spiritual approaches in acknowledging and facing human mortality and death. For clients who are philosophical, spiritual or religious, encouraging them to read about or devote some time of their day to their beliefs or a particular doctrine would lead to a sense of inner peace and tranquility.

Counselling Interventions with People with HIV and AIDS:

The goal of counselling interventions is to help the person with HIV or AIDS live with the illness in the best possible way. (Specific guidelines for HIV infected persons or persons with AIDS are given in Appendix 2). Interventions which could be helpful are :

Individual interventions :

- **Education**
  Information about the illness itself, risk reduction, normal emotional responses to the diagnosis, etc.

- **Individual counselling**
  Adopting a non-judgemental stance, empathizing, normalizing/universalizing responses, active listening, supporting coping skills.

- **Provision of support**
  Emotional support, support and reinforcement for risk reduction and behaviour change.

- **Assistance with disclosure of diagnosis**
  Offering, when possible, to help the client disclose his/her diagnosis to spouse/partner and/or family members.

- **Grief counselling**
  Talking directly about reactions to the losses the client has already experienced or anticipates, talking directly about death and dying, helping the client take care of practical matters (provision for children, legal matters, finances, etc.), assisting the client in addressing unresolved emotional and relationship issues.

- **Crisis intervention**
  Identifying and validating client's ability to cope with past life crisis, assisting with concrete problem solving, encouraging client's active and positive participation in current situation, increasing awareness of options, encouraging expression of feelings within counselling session, mobilizing support network, providing client with appropriate referrals.

- **Substance abuse treatment**
  Providing referral for substance abuse treatment if client is experiencing negative consequences from his or her use of alcohol and/or drugs.

- **Encouragement of client's active participation to increase sense of empowerment**
  Learning more about the illness, changing health behaviours, helping others, increasing involvement with spiritual and religious practice.

- **Skills training**
  Problem solving, coping skills, stress management.

- **Mobilize social support**
  Facilitating contact with other people.

- **Advocacy**
  On behalf of client who is unable to do so on his or her own, for example, financial assistance, basic living concerns, medical and treatment issues.

Family Interventions:

The goal of counselling interventions for the family is to help them come to terms with the impact of the HIV or AIDS diagnosis on their lives. Among interventions which could be helpful are:

- **Education**
  About the disease, transmission, what to expect in terms of the course of the illness and emotional responses.

- **Assistance to family**
  Clarifying conflicting feelings about the disease, stigma, reactions to disclosure of the diagnosis and risk factor(s), fears of contagion, reactions to anticipated death of the family member and other losses, shame, impulse to reject; giving everyone opportunity to share their viewpoint.

- **Conflict mediation**
  Alliance with supportive family member; establishing common ground; mediating conflicts.

- **Modelling positive interaction**
  Diffusing fear about contagion by acting as a role model for family members when interacting with the person with AIDS.

- **Mobilizing family support**
  Helping maximize support for family members within the family and from friends and community members where possible.

- **Encouraging family members to take action**
  Finding out more about the disease, helping others.

- **Supporting the spouse/partner**
  Validating their concern about their own risk of HIV infection, reinforcement for behaviour change, exploration of satisfying and safe forms of sexual contact and intimacy.

- **Grief counselling**
  Talking directly about reactions to the losses already experienced and/or anticipated, talking directly about death and dying, helping the family take care of practical matters (provision for children, legal matters, finances), assisting the family in addressing unresolved emotional and relationship issues.

Group Interventions :

Any intervention which facilitates interactions among people with HIV or AIDS, or among family members, will help to decrease isolation and stigma while providing education, social support and role models for coping with the illness. Peer groups can be focussed or targeted to a specific audience such as people with AIDS, couples, parents, gay and bisexual men, women, etc. Group interventions are extremely helpful, but often difficult to assemble. Ways to promote interaction among people with similar experiences of HIV and AIDS include:

- **Peer groups**
  Education, social support, emotional support, problem-solving.

- **One-to-one peer contact**
  In person or by telephone. Anonymity and confidentiality can be more easily protected.

- **Formal or informal groups**
  Groups of people affected by AIDS who work towards public education and advocacy.

ACTIVITY 8: Group Work : HIV Risk Assessment

Time: 45 mins

Materials: HIV Risk Assessment forms for each participant

Objective:

The purpose of this activity is to become familiar with the information that needs to be gathered in HIV risk assessment and to understand the client's experience when asked very personal questions that are part of an HIV risk assessment.

Procedure:

Ask participants to fill out the HIV risk assessment **(worksheet 2)** form about their lives. Explain that these risk assessment forms will remain in their own hands. They will not be asked to share their responses with anyone else.

Remind participants that the purpose of the activity is not to evaluate or see results of the risk assessment form. The form is only a guideline regarding the kind of information to be gathered in the session, not a recommended tool for using with clients.

After five minutes, divide the large group into small groups of four. Ask them to discuss the following questions for 10 minutes :

- How did you feel as you completed the form?
- Were there questions you were unwilling to answer or wanted to avoid?
- What did you learn from this experience that may help you when you are conducting risk assessment interviews with clients?

Next, assign each participant the role or title of "Truck Driver" "Commercial Sex Worker", "Intravenous Drug User", "Pregnant, Married woman", "Undergraduate hostel student" and ask them to imagine themselves as that person and think about what their lifestyle and relationships would be like. Then, instruct the participants to fill our a fresh HIV Risk Assessment Form as they would if they were the "imagined person" that they have been designated by you (the facilitator).

After 5 minutes, divide them again into small groups of four. Ask them to share their feelings around the following topics for 10 minutes :

- Was it easy or difficult to fill in the form as the person you were designated to be?
- What was different in the responses you gave in this form Vs. when you filled out the form as yourself?
- Compare your inner feelings while filling the form now and while filling it earlier.

Bring the small groups back to a large group and discuss the activity with the following questions while keeping in mind the points for discussion given below :

- Why might it be difficult for clients to be honest in disclosing information about their high-risk behaviours?
- As a counsellor, what can you do to help clients feel more comfortable in talking honestly about their HIV risk?
- What methods or approaches for assessing risk might be most helpful for the client?
- What has impacted you the most in this exercise?

Points for discussion: Reasons why people will not disclose honest information about their risk behaviour:

- Fear of recognizing one's risk.
- Denial of risk.
- Reluctance to disclose participation in culturally taboo behaviours.
- Fear of stigma and discrimination.
- Unwillingness to look at one's past behaviour.
- Discomfort in discussing sexual behaviours and substance use openly.
- Discomfort in discussing personal matters with a stranger.

Note to trainer: This activity works most effectively as an introductory and sensitizing activity. The trainer presents the Risk Assessment Counselling Checklist in **OHP # 8** to review the main steps of a risk assessment counselling session.

WORKSHEET 2

HIV Risk Assessment Form (For Activity 8)

Sexual History

1. Since 1987, have you had sexual intercourse (anal, vaginal or oral) with:

   - anyone infected with HIV? yes _____ no _____ don't know _____
   - anyone who has used intravenous drugs? yes _____ no _____ don't know _____
   - anyone who has shared intravenous drugs? yes _____ no _____ don't know _____
   - anyone who has gone to hospital for treatment where injection needles were not changed? yes _____ no _____ don't know _____
   - anyone who has ever received blood transfusions or other blood products (for e.g. for hemophilia or other coagulation disorders)? yes _____ no _____ don't know _____
   - any man who had sex with other men? yes _____ no _____ don't know _____
   - any man or woman who has had many sexual partners before you? yes _____ no _____ don't know _____
   - any man or woman who has had sex with anyone in the above categories? yes _____ no _____ don't know _____

2. With these partners, you have engaged most frequently in which of the following sexual practices (please tick the relevant ones):

   - vaginal and/or anal intercourse without a condom
   - vaginal and/or anal intercourse with a condom
   - oral intercourse (fellatio, cunnilingus) with a barrier
   - oral intercourse with a barrier
   - masturbation, body rubbing, dry kissing

3. If you used a condom for anal, vaginal or oral intercourse, did you use it (please tick one):

   - all the time?
   - sometimes?
   - once in a while?

4. How many sexual partners (with whom you have not practiced safe sex), have you had in :

- the past 10 years? --------
- the past 3 years? --------
- the past year? --------

Substance Use and/or Needle Sharing

5. Have you ever used drugs intravenously?
   yes _____ no _____
   if yes, have you ever shared needles or other paraphernalia:
   yes _____ no _____

6. Have you ever shared unsterilized needles for other purposes such as medications, tattoos, acupuncture?
   yes _____ no _____

7. Do you drink alcohol or use non-IV drugs?
   yes _____ no _____
   if yes, have you ever had difficulty remembering what happened while you were using drugs or alcohol?
   yes _____ no _____.

Blood Transfusion and/or Blood Products

8. Have you ever received any blood transfusion or blood products (for hemophilia or other coagulation disorder)
   yes _____ no _____
   if yes, in what year? _____

OHP # 8

RISK ASSESSMENT COUNSELLING CHECKLIST

1. **Explain the purpose of HIV risk assessment.**
2. **Assess client's knowledge about modes of HIV transmission. Clarify any misinformation.**
3. **Ask the client to assess his or her current and past high risk behaviours.**
4. **Ask the client to summarize his or her risk of HIV infection. Discuss any concerns and clarify misconceptions.**
5. **Summarize the discussion about the client's HIV risk, leading into a discussion about risk reduction.**

ACTIVITY 9: Group Work : Introduction to Pre-test and Post-test counselling.

Time: 45 mins

Objective:

The purpose of this activity is to familiarise the trainees with the essential elements and issues of pre-test and post-test counselling.

Procedure:

Divide trainees into small groups of 4 people. Ask each group to make the following list and record it on a large paper.

- Some of the things a counsellor might do or say during a pre-test situation.
- Some of the things a counsellor might do or say to prepare a client for a positive result.
- Some of the things a client might say or do after hearing the positive result.

Give the group 15 minutes for this listing. Ask all the groups to read out their lists for each of the three situations. Based on the above sharing, the trainer discusses the essential elements -related to antibody testing counselling and highlights the main features of pre-test, post-test counselling sessions.

ACTIVITY 10: Role Plays : Pre-Test and Post -Test Scenarios

Time: 1 hour

Objective:

This activity is designed to help the participants understand that pre-test and post-test counselling are inter-related activities.

Procedure:

The trainer asks the participants to form two sub-groups. Each sub-group gets a card with Kishore's scenario - one as a pre-test and one as a post-test situation.

Two volunteers in each sub-group are recruited to play the roles of counsellor and counsellee for their card-scenario. The trainer instructs the two groups to prepare and help the volunteers rehearse their role play for 20 minutes. After this preparation time, the two sets of volunteers enact their scenarios for the full group for 7-10 minutes each.

After each role play, all the participants discuss the kind of counselling provided and issues that were important from the clients' point of view. At the end of the two role-plays and discussions, the trainer ends the activity, making sure that all trainees recognize the importance of linking counselling to HIV testing and pre-test and post-test counselling.

Scenarios

#1 Kishore is a 32 year old married man with two children He has been having an affair with another married woman, Sheela, for the last few years. A friend of Sheela has recently been diagnosed as infected with HIV. Kishore is worried about his wife and children. He comes to seek help.

#2 Kishore is a 32 year old married man with two children. He has been having an affair with another married woman, Sheela, for the last few years. He had gone for testing because he was worried after hearing about a friend who had been diagnosed as HIV positive. Kishore had received pre-test counselling from you and has come back to you after the result. Kishore has tested HIV positive. He disbelieves the test. He also expresses his concern about the future of his family.

ACTIVITY 11: Group Discussion : Counsellor's Fears

Time: 30 mins

Materials: Large paper, 3 X 5 cards or small sheets of paper, pencils.

Objective:

The purpose of this activity is to discuss counsellors' fears about breaking the news about test results. "Breaking the news" refers to telling a client that he/she is infected with HIV, a difficult and uncomfortable task for most counsellors. There are many reasons for this. Some are:

- The counsellor is inexperienced and not sure what to do or say.
- The counsellor does not understand the natural history of HIV and cannot explain clearly what a positive test result means.
- The counsellor always feels uncomfortable when people express anger openly.
- The counsellor does not know where to send the client for medical care or legal help.

In this activity, trainees will discuss their fears and concerns about breaking the news.

Procedure:

Ask participants to write on a card or small piece of paper the two things that worry them the most when they have to break the news of a positive diagnosis to a client. Collect the cards. Mix up the cards and give one to each participant. (Don't worry if a participant ends up with his/her own card). Have each person read what is on his/her card. The trainer should list all the concerns on a chalkboard or large sheet of paper, eliminating duplications.

Explain that these fears and concerns can result from lack of knowledge, lack of skills, or the counsellor's emotions, attitudes or personal situation. It is important for participants to understand the basis of their fears or concerns. Some of these can be avoided if counsellors acquire more knowledge or learn and practice new skills. When the counsellor's concerns result from his/her own situations or from personal feelings and attitudes, it is often best to discuss this with other HIV/AIDS counsellors or with senior counsellors.

On a large paper or a chalkboard, write the following as three separate headings:

- Knowledge
- Skills
- Personal Issues

Now, re-examine the group's list and decide (with the trainee's inputs) whether each fear or concern can be lessened by increasing knowledge, improving skills, or acknowledging the personal issues that may arise for the counsellor. The trainer should then rewrite the fear or concern being discussed under the appropriate heading. Some fears could be best addressed in more than one category and should be listed in each relevant category. Discuss how these fears or concerns affect the counselling session and how counsellors can best respond to their own fears.

Summary of Major Points:

- Fears might include:
  - The client will commit suicide.
  - The client will walk out of the counselling session.
  - Clients will not come back for follow-up counselling or medical care.
  - The client will be angry at the person he/she thinks infected him/her and will try to hurt that person.
  - The client will knowingly try to infect others.
  - The client will get angry with the counsellor.
  - The counsellor will not know how to respond to extreme client reactions such as anger, depression, uncontrollable crying, or hopelessness.

- Breaking the news is a difficult and uncomfortable task for all of us. Sometimes it is difficult because it is so unfamiliar and the counsellor does not have enough knowledge or skill to carry out the task. Other times, breaking the news is difficult because the counsellor gets personally involved with the client or because the counsellor feels that he/she cannot really help the client.

- Frequently, counsellor's fears lessen after they have had a chance to practice breaking the news. They gain confidence with experience and begin to develop a wide range of response to clients.

ACTIVITY 12: Guided Imagery : Supportive Counselling

Time: 1 hour

Objective:

This exercise helps people to explore coping and supportive strategies for managing loss. They also learn to identify their strengths and weaknesses in helping others cope with loss and grief. By getting in touch with their own feelings the participants understand the essence of supportive counselling and can begin to explore their skills in working with HIV-infected people and/or their families.

Procedure:

Explain to the participants that the guided imagery activity will involve them in recalling in detail a significant loss in their life. This loss could be:

- the death of a person close to them
- a separation or divorce
- loss of health
- change of employmen

If the most significant loss is too recent or too painful, suggest that the participant recall another loss. Those trainees who find the entire activity too stressful should be allowed to pass it by. Participants should feel free to reveal only that which they feel comfortable discussing. Tell participants that they can imagine a loss if they cannot think of one. If they find constructing mental images difficult, suggest that they recall the situation in whatever way they wish. Leave a time gap between each set of questions asked so that the participants may internally feel and think of the situation.

In a calm tone of voice relay the following instructions to the participants:

> *"Make sure your are sitting comfortably with your feet flat on the floor. You may want to close your eyes to help you focus and relax. Please do not talk to each other or ask me any questions during this session. As I guide you through this exercise pay attention to your thoughts and feelings as you become aware of images and memories. Think of a significant loss you have experienced in your life. It may be the death of a loved one. If this is too recent and painful, think of the loss of someone else. If you have not experienced the death of someone close to you, recall a loss associated with separation or divorce, loss of health, change of employment or any other loss that caused you grief. Picture this person or event in your mind. Notice what you are feeling and thinking."*

"Now think back to the events surrounding the loss and what led up to it. Fix in your mind an image of how you first learned of this potential loss. If there was no forewarning, concentrate on an image of when you first learned of the loss. (or diagnosis of a terminal case)."

What was your initial response?

- What were you experiencing?
- How did others respond to you?
- What helped you most at this point?
- What helped you least?

Allow some time for trainees to reflect internally. Then continue:

"Now make a mental image of yourself after this initial shock but before the death or change. If there was no time between the two, imagine this period. Notice your feelings and thoughts."

Then, ask the following questions to enable participants to explore internally. Answers should not be called out as this is still in the guided imagery.

- What was this period like for you?
- How did you interact with others?
- What emotional and behavioural changes occurred?
- What helped you survive this period?
- What made it difficult?

"Now imagine the actual death or loss and the two weeks following it. Make a picture of that time in your mind."

- What are you feeling and thinking?
- Who is around you?
- What is most helpful about what they are saying or doing? If they are not helpful, what would you like them to do differently?
- What helps you most at this moment?

"Now imagine yourself six months later."

- Where are you? What are you doing?
- What are you feeling and thinking?
- Do you notice any physical or behavioural changes?
- What has changed in your life?
- What has helped you get through the last six months?

"Now make a picture of yourself today. Notice what you look like, what you are wearing. Notice how you feel. Imagine the other participants in the room. Make a picture of where you are sitting in the room. Picture the person next to you. Think back to an earlier session and recall what you were thinking then."

"Bring your attention back to yourself, sitting in this room. Notice your breathing. Feel your feet on the ground. When you feel ready, open your eyes. Take a moment to readjust to the room. If you are feeling emotional, take a moment to recompose yourself. When you feel ready, find a partner and spend 5-10 minutes discussing what you are feeling as a result of this guided imagery. Begin to think about and discuss what you learned about yourself and your experience with loss".

Invite the pairs to join another pair, making groups of four people. Give each group several large sheets of paper and a pen or marker. Ask the groups to choose a recorder.

Ask the groups to discuss the following questions for the next 20 minutes, recording their responses on the large sheets of papers:

- What did you learn about yourself and your experience with loss?
- What helped your most:

  1. When you first learned about the potential death or loss?

  2. At the time of the death or loss?

  3. Up to six months after the loss?

- What helped you least during each of these periods?
- What does this tell you about helping people with HIV infection and AIDS and about helpign their families to live with a life threatening illness and/or cope with an actual death?
- What are your personal strengths and weaknesses in helping others to cope with loss and grief?

Call the groups back into a large group and ask them to tape their sheets of paper to the wall. Discuss the responses in the large group.

ACTIVITY 13: Role Reversal - Empathy (Optional)

Time: 25 mins

Objective:

The purpose of this activity is to practice understanding and empathising with a client's experience from his or her perspective.

Many times our client's situations remind us of our own feelings, situations or experience. Sometimes this makes us react positively to the client; other times we can have negative emotions such as anger. This is a natural and common human experience. As HIV/ AIDS counsellors, we need to become aware of our tendencies to feel both positive and negative emotions towards our client and at the same time, develop the ability to feel empathy towards some aspects of all of our clients. In this activity we will examine our understanding of and our ability to develop empathy toward others.

Procedure:

Read the following story to the group:

> Anil and Aruna have been married for 7 years. They have three children aged 5, 3 and a newborn. They met in secondary school and married soon after that. They love each other very much and have a good marriage. Anil and Aruna were very excited about the birth of their third child. Anil works in a textile factory. He has been quite successful at work and has just been promoted to a senior managers position. Aruna works as a secretary. Aruna suspects that Anil has had some extra-marital affairs during the time they have been married, although they have never discussed it. Anil is a good father and husband. Anil has been involved with several women since his marriage. Although Anil knows about using condoms to prevent AIDS, he didn't think he needed to worry since the women he had seen were nice, clean women. Besides he did not see them more than a few times each. Since the birth of their newborn Aruna has been sick and so has the newborn child. She was tested for HIV and the results are positive.

Ask the group to think about the position of both husband and wife and the events they are facing. Ask participants to decide whether they have more empathy for Anil or Aruna in this situation. Then ask them to write down some possible thoughts and feelings of the person they have chosen.

Next, ask all those who have greater empathy for Anil to go to one side of the room and those who have greater empathy for Aruna to go to the other side of the room. Next, ask participants to find a partner from across the room and find a comfortable place to sit down. If there are an unequal number of people on each side of the room, some groups can have three people (two from one side of the room and one from the other).

Instruct the pairs (or groups of three) that they are now to change sides i.e. imagine they are the other person (Anil or Aruna) - not whom they have empathy for. Now ask participants, in their new roles, to explain to the other what they are thinking and feeling. Give participants 5 to 10 minutes for this discussion.

Next, ask participants to step out of these roles and again think of the person for whom they originally had greater empathy. Using the thoughts and feelings they had written at the beginning of this experience, (in step 1) ask each group or pair to discuss what they had written and why they had more empathy for one person than the other. Give the groups 5 minutes for this discussion. Return to the large group and discuss this exercise. Ask the group:

- What did you learn by changing sides?
- How did having more empathy for Anil or Aruna influence your empathy for the other person in the story?
- Would you be able to counsel both persons?
- What can help you develop empathy for clients, even when they trigger negative feelings in you because of your personal experiences or reactions?

Summary of Major Points:

- It is natural to feel greater empathy for some people as compared to others.
- It is also possible to develop empathy for clients even if you do not feel empathy for them naturally.
- As an HIV/AIDS counsellor, it is very important to develop the skill of empathising with individuals whose behaviour and values are different from your own and to be sensitive to the perspectives and feelings of both the HIV infected person and his/her family members.

SECTION 3D

UNRESOLVED ETHICAL LEGAL ISSUES RELATED TO HIV ANTIBODY TESTING

HIV testing is a complex subject involving issues related to ethics and human rights. Some of the critical issues are outlined below.

Why Test?

When someone seeking to be tested gives no history of high-risk behaviour, the counsellor should enquire into the reasons why testing is sought, and offer preventive and supportive counselling. The counsellor may discourage people who do not want to know the test result from undergoing the testing, but should make it quite clear to them that they must behave as if they were seropositive in order to prevent infection in themselves or transmission to others.

Mandatory Testing

In some places, there is much concern that without compulsory testing, people will not admit to risk behaviour and infection will not be detected. This risk must be weighed against the cost and consequences on social order and basic human rights. Counselling should and encourage voluntary action to bring about behaviour change. Mandatory testing should extend only to blood and blood fractions, organs or for invitro fertilization or artificial insemination.

Informed Consent

Informed consent is another difficult issue. In places where health care workers usually behave in an authoritarian manner, it may be tempting to 'order' a person to be tested and take it for granted, that it is alright for one to do so. Counsellors know, however, that people are more likely to respond positively to information and counselling if they themselves take part in decision-making. Therfore as s far as possible, counsellors should ensure that each client understands the procedures, their limits and the positive psychosocial consequences prior to being tested. This may require orienting and educating colleagues and other health care workers/ professionals in the setting about the importance of informed consent and pretest counselling.

Given our low literacy levels, lack of health awareness and the very complex nature of HIV infection, informed consent as it is understood in the West is very difficult to apply in the Indian context. Each time a person is treated by a doctor, relevant information is imparted on the basis of which some form of consent is sought to further the course of treatment. Though a patient's consent is not formally recorded, enough information is imparted to the patient to help him/her take the required test. Informed consent, integrated counselling service and facilities for voluntary testing are the ideals we need to work for.

Confidentiality

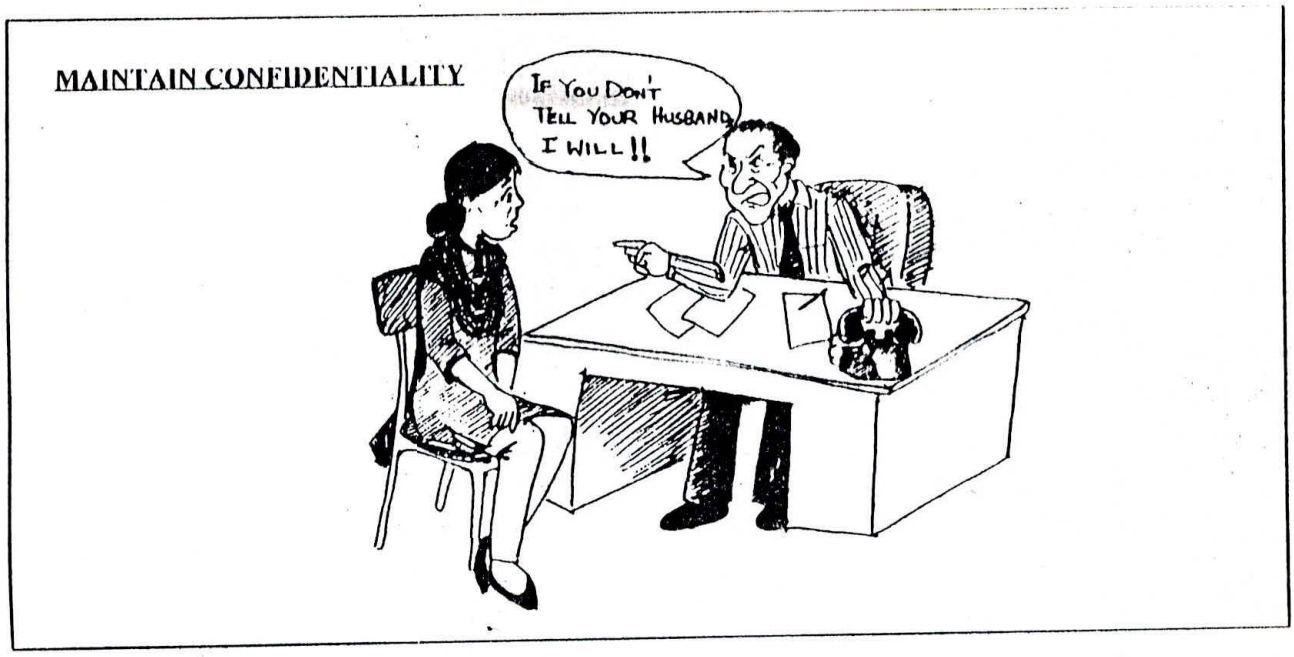
The infection may bring into the open many issues which were regarded 'personal', for example, 'sexual orientation. There arises a need to discuss personal issues with apparently unknown people like doctors, counsellors. It is very important that full confidentiality is assured in such a situation. Without it, the individual will not be able to share his/her concerns to the fullest extent. And, if this sharing is not done, effective counselling will not be possible. Another fallout would be that the individual will not be able to receive any information on primary or secondary prevention activities. Awareness of this issue of client participation and cooperation is vital in counselling.

Given the possibilities of discrimination, ostracism and personal self-blame when an individual is diagnosed as HIV-positive, it is all the more important that confidentiality be guaranteed. The counselling relationship must be based on the understanding that whatever is discussed will remain confidential until and unless the client decides to share the information with someone else.

However, because of the very public nature in which our hospitals and clinics function, some health workers/staff could make disclosures out of carelessness that stems from these 'public conditions'. Therefore, in evolving the norms of confidentiality for hospitals and other health settings, regulations for keeping medical records confidential need to be widely disseminated among all classes of hospital employees. Some sanctions should be set up for offenders which range from mild to severe (e.g. from warnings to a stricture/documentation to stronger departmental actions). Counsellors, physicians, other health care staff and the media also need to be aware that, on the legal side, wilful breach of confidentiality is punishable under Common Law. Negligence, per se, is a criminal offence and hence, breach of confidentiality of the identities of those living with HIV/AIDS, both wilful and negligent, is punishable under law.

The ethical issues in 'confidentiality' revolve around the risk of transmitting infection to partners by an HIV-positive client. In some circumstances, counsellors many decide to break confidentiality, for eg., to notify the sex partners, unsuspecting spouse or needle-sharing partner of an infected person. However, the first step should be to counsel and motivate the client to share this information with his/her concerned partner(s). If the individual refuses to do this, the counsellor/social worker/physician should make this disclosure to ensure safety after consulting a supervisor/colleague. Another common situation in this arena is that of arranged marriages/ prospective planned marriage. It is incumbent on the counsellor to motivate the client to disclose his/her HIV status to a prospective partner/fiance. Since marriage to an infected person could endanger the life of the unsuspecting prospective partner, the counsellor could carefully weigh the option of making the disclosure himself/herself.

The staff of the counselling unit/center need to agree on this issue, and will need inputs on developing relevant skills. The concept of confidentiality can be extended to mean "shared confidentiality" where a team of health workers in the health care or counselling setting shares the confidentiality, but agrees to protect it from anyone outside the team.



Partner notification

This issue is linked with confidentiality and has been discussed there too. There may be some instances where the counsellor or other health care workers feels that confidentiality needs to be broken, for example, to notify the sex-partner of an infected person when the client has refused permission to do so. The Consensus Statement from the WHO Consultation on Partner Notification for Preventing HIV Transmission specifies that in such situations, the health care provider "will be required to make a decision consistent with medical ethics and relevant legislation." In general, where confidentiality is preventing appropriate measures for avoiding the spread of HIV, it may be necessary to reconsider the situation in that particular case" (WHO AIDS Series 8, WHO, Geneva, 1990).

Equal Opportunity

Test results may be lead to discrimination against the infected. This may be in the form of social ostracisation, refusal of medical treatment and attention, discrimination in occupation, employment in social services like housing, education and such others. Some risk behaviour groups may be discriminated against, for example, homosexual, hemophiliac, family members of infected, some ethnic groups. The right of the patient for equal opportunity must be remembered when discrimination occurs.

It is recommended that counsellors should advocate and lobby for no discrimination against infected persons in terms of employment, health care, education, life insurance and immigration. Health care professionals do have an obligation to treat patients with HIV/AIDS without discrimination, to counsel them and to update their own professional skills.

Other considerations

Though there is no specific legislation in this country, some legal issues to be considered in the context of the above would be: compulsory testing, isolation, immigration, euthanasia, protection of health workers against risk of infection, eligibility for medical insurance and life insurance, pre-employment screening, reservations, pre-marriage testing and divorce and such others. Brain storming needs to be done regarding these issues.

Some legislation, at present, like the Consumer Protection Act, 1986 talk about consumer rights. Some of the rights of the consumer under the Consumer Protection Act 1986 are:

- Right to protection against marketing of hazardous goods.
- Right to information about quality, quantity standard, price, etc. of goods.
- Right to protection of interest.
- Right to access for variety of services.
- Right to seek redressal and
- Right to consumer education

What we need to focus on here is : Can a patient be called a "consumer"? If yes, under what circumstances? There is a strong and urgent need for a broad-based law that explains the transmission modes, protects the dignity and rights of the patients and addresses key questions like non-discrimination, testing, confidentiality, screening of blood and the role of the health services. But, until that happens, it is the responsibility of the health and counselling professionals to address these issues in their own settings and establish some guidelines for their services and activities.

Suggested Readings

Gautam, S.(1989): The AIDS Prevention Bill, 1989; Protection or Prosecution? The Lawyers, October, p. 7-10.

Grover, A. (1990): AIDS victims- Isolated by the law The Layers, October, p- 4-7

Grover, A. (1992): AIDS act now! ... Before it's too late. The Lawyers, May, p. 4-11

Ivey & Glucksten : Basic Attending Skills

Kubler - Ross. E. (1969): On Death and dying. Macmillan

McGoldrick, M., Pearce, J., & Giordano, J. (1984) : Ethnicity and Family Therapy The Guilford Press.

Panos Dossier (1990) : The Third Epidemic, Ch. 9 : AIDS, the law and human rights. London : Panos Publications

Satir, V., (1988): The New Peoplemaking. Science and Behaviour Books Inc

ACTIVITY 14: Case Studies: Ethical & Legal Issues

Time: 45 mins

Objective:

The objective of this activity is to provide the trainees with an opportunity to examine, understand and work through some of the difficult, sometimes controversial, ethical and legal issues that are related to HIV/AIDS.

Procedure:

Present OHP #9 at the start of this activity to outline the main ethical and legal issues linked with HIV/AIDS. Briefly describe the implications and meaning of each term on the OHP. Then, display Case study #1 on **OHP #10** and ask each participant to write on a piece of paper:

(a) What issues does this case study present/indicate?
(b) What are various options or alternatives for action in this situation? (encourage them to generate as wide a variety of alternatives as possible).

Allow 5 minutes for this step. Invite 3-4 participants to share their responses and thoughts. Note these on a flipchart and make concluding remarks about the general pattern of thinking or action that emerges from the responses. Allow 10 minutes for this discussion. Repeat this process for Case study #2 **(OHP #11)** and Case Study #3 **(OHP #12)** separately. Try to involve as many participants as possible by asking different people to share their responses, for each case study.

Summarize the activity by underlining that these are difficult areas and for some issues there may be no clearcut answers. Emphasize that each participant should examine his/her own work situation and come up with options that would be suitable for that environment.

ACTIVITY 15 : Review Questions

Time: 20 mins

Procedure:

After the participants have answered the review questions **(Worksheet 3)**, the facilitator should ask them to call out/read aloud their answers. He/she should request 2-3 participants to call out their responses for each question. Ensure that different people get an opportunity to share their responses. In cases of factual questions (nos. 1,2 and 5), any misconceptions or wrong answers should be corrected. Treat the other three questions as personal opinions and general discussion points.

OHP # 9

ETHICAL AND LEGAL ISSUES RELATED TO HIV-TESTING AND COUNSELLING

1. **Mandatory Testing**
2. **Informed Consent**
3. **Confidentiality**
4. **Partner Notification**
5. **Equal Opportunity and non-discrimination**

OHP # 10

CASE STUDY # 1

Harish, a 22-year old waiter in a restaurant, went to a nearby general practitioner looking for a cure for discharge from his penis. The general practitioner prescribed some antibiotics and also sent him to the municipal hospital for an HIV test by just handing him a written note for the pathologist. Harish came to the hospital and got himself tested, after which he was asked to go see the hospital social worker. The test results would be passed onto the social worker after analysis. Harish does not know what he has been tested for and has come to the social worker to fix an appointment, as instructed by the pathology department. This general practitioner has been referring other cases also in the same fashion for the past 5-6 months. What are the issues to be examined in this case?

OHP # 11

CASE STUDY # 2

A large pharmaceutical company has heard of HIV/AIDS and its rapid spread in all parts of India, especially the metros. The company has a total strength of 10,000 employees with about 5% falling in the top management cadre/level. There is a physician doctor appointed as Chief Medical Officer with the company, along with 3-4 consultant/specialists who come in twice a week. The managing committee feels it would be a good idea to test all the blue collar workers, to start with, so as to detect HIV infection prevalence in the company workforce. It has put this recommendation to the Chief Medical Officer to give his comments and decision.

What are the implications or possible effects of such a measure? What would be the reactions of people in different positions or at different levels, in the company?

OHP # 12

CASE STUDY # 3

Ashish is 25 years old and works as a junior executive in a bank. During his college days, he used to go out a lot with his friends for drinks, movies, parties, etc. Once, the full group had gone to a small, two-star hotel where they had experimented with sex with a couple of commercial sex workers (organised by the staff of the hotel). Early this year, Ashish had seen 3-4 girls for marriage as he and his parents felt it was time for him to settle down and get married. He liked one of them. The girl's family also liked the match and the two had gotten engaged three months back. The marriage was scheduled in three month's time.

Ashish had read about HIV/AIDS and got slightly worried about one month before his engagement. He had gone to an HIV -anonymous testing and counselling centre. After some counselling, he had agreed to be tested and the results came out positive. He has met with the counsellor four - five times but has been refusing to inform anyone in his family (or his fiance and her family) of his status. He is worried about their reactions and the consequences and refuses to take the risk. He has discussed children with his fiance and both he and his fiance are looking forward to having children in the near future.

What are the dilemmas facing the counsellor?

WORKSHEET : 3

Review Questions

1. **Which two communication skills would you rate as the most essential in HIV/AIDS counselling?** Why?

2. **Identify three kinds of supportive behaviour and three kinds of non - supportive behaviour in the counselling process that are relevant in the Indian context.**

3. List the principles of HIV/AIDS counselling.

4. How do you perceive the role of the counsellor?

5. What are the chief characteristics of:
   a. Pre test counselling
   b. Terminal care counselling

6. Please list two ethical/legal isues that you feel are very crucial to your city or state vis -a- vis HIV/AIDS counselling services. Give reasons for your choices.

MODULE 4
PSYCHOLOGICAL ISSUES AND SEXUALITY

EXPECTED OUTCOME:

The trainees will gain an understanding of sexuality in terms of sexual orientations and practices in relation to HIV/AIDS. Trainees will also be sensitized to the skills in discussing sexual practices, sensitive issues and will be made aware of the psychological issues in relation to HIV/AIDS.

MODULE AT A GLANCE
TOTAL TIME - 4 HRS 55 MINS.

CONTENT SECTION

PSYCHOLOGICAL ISSUES
SEXUALITY
SEXUALITY IN INDIA
GUIDELINES ON TALKING ABOUT INTIMATE TABOO TOPICS

ACTIVITY SECTION

EXERCISE: WHERE DO I STAND	:	30 mins
CONTENT PRESENTATION	:	1 hour
EXERCISE ON STIGMA	:	1 hour
GROUP WORK	:	30 mins
PAIRED EXERCISE	:	30 mins
BRAINSTORMING	:	30 mins
GAME AND DEMONSTRATIONS	:	45 mins
REVIEW QUESTIONS	:	10 mins

OVERVIEW

Psychosocial counselling is particularly important in dealing with HIV/AIDS and requires an understanding of the ways in which people react to fear of infection or a threat to life. Some of the emotions (which are normal and common) people experience and express in testing and diagnosis situations are : shock, disbelief, bargaining, denial, guilt, fear, anger, suicidal thinking and depression. Human sexuality is a very important aspect of people's lives and needs to be well understood by counsellors when doing HIV prevention and supportive counselling. It refers not only to sexual intercourse/activities but also to feelings, attitudes and values. One's emotions and feelings of love also play a large role in shaping one's sexual behaviour. What is considered as normal by one person in one society may be considered as abnormal by someone else in another social environment. It is important for counsellors to be non-judgmental about client's sexual preferences and orientation and keep their focus on exploring safer sex options. Some of the sexual behaviours that need special attention in connection with STDs and HIV in India are abstinence, masturbation, nocturnal emissions, oral sex and homosexuality.

To obtain an understanding of the client's behaviour which has led to or places them at risk of HIV infection, the counsellor must be able to obtain information on sensitive topics such as sex practices and drug injecting. This can be done only through informed questioning. Questions must also be used to verify that all clients understand the basic information on HIV infection and its prevention. Clients must be given advice on safer sexual practices, but told that the only completely safe behaviour is sexual abstinence or a monogamous long-lasting relationship. The latter is particularly important in cultures in which advice on safer sexual practices is not well received. In discussing levels of risk, counsellors will have to talk to clients about sensitive topics, and will need to decide how ready they are to talk about them. The consistent use of condoms must be emphasised and instructions given on how they should be used.

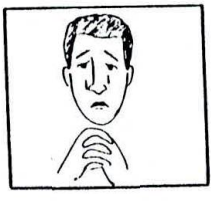
PSYCHOLOGICAL ISSUES

As AIDS has no cure, the threat of HIV infection is a threat to an individual's very existence. People faced with this very stressful event respond in a variety of ways. The news of having HIV infection may produce some very distinct psychological effects. It is important to recognise the impact of the news of HIV infection on the infected individual in the financial, legal, familial and occupational aspects of his or her life.

The implications may need to be identified and managed by referral & other appropriate mechanisms. A variety of emotions have been recorded vis-a-vis people's reactions to HIV testing and to the diagnosis of a positive result. It is important for a counsellor and other health care providers to understand these reactions and support the clients experiences while they work through these emotions. The major emotions are enummerated below.

Shock and disbelief

The news of HIV infection causes intense emotional shock. It disrupts the patients usual coping strategies. Total loss of control, break down or emotional withdrawal are a few of the reactions.

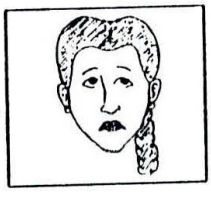


Bargaining

Some people try to bargain. They think God will cure them if they stop having sex. Some people think they will get cured if they have sex with a virgin or a child.

Denial

Some people may respond to the news of their infection or disease by denying it. For some people, initial denial can be a constructive way of handling the shock of diagnosis. However, if it persists, denial can become counter-productive, since people may refuse to accept the social responsibilities that go along with being HIV positive.

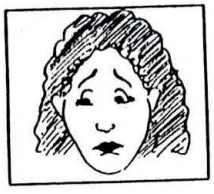


Guilt

A diagnosis of HIV infection often provokes a feeling of guilt over the possibility of having infected others that, or over the behaviour that may have resulted in the infection. The patient may also feel guilty about the sadness the illness will cause loved ones and families, especially children. Previous events that may have caused pain or sadness to others and remain unresolved will often be remembered at such times and may cause even greater feelings of guilt.

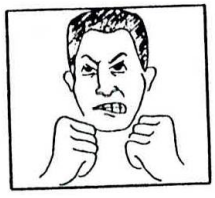
Fear

People with HIV infection or disease have many fears. The fear of dying and particularly, of dying alone and in pain is often very evident. Fear may be based on the experiences of loved ones, friends or colleagues who have been ill with or died of AIDS. It may also be due to not knowing enough about what is involved and how the problems can be handled. Fears should be openly discussed in the context of managing the difficulties, and with the help of friends and family or with the counsellor.



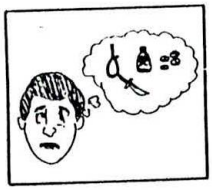
Loss

People with HIV related diseases experience feelings of loss about their lives and ambitions, their physical attractiveness and potency, sexual relationships, status in the community, financial stability and independence. Perhaps the most common loss that is felt is the loss of confidence.



Anger

Some people become outwardly angry because they feel that they have been unlucky in contracting the infection. They often feel that they have been, or information about them has been badly or insensitively managed. Anger can sometimes be directed inwardly in the form of self blame for acquiring HIV, or in the form of self destructive behaviour.



Suicidal activity or thinking

People who are HIV infected have significantly increased risk of suicide. Suicide may be seen as a way of avoiding pain and discomfort or of lessening the shame and grief of loved ones. Suicide may be active (i.e. deliberate self-injury resulting in death) or passive (i.e concealing or disregarding the onset of fatal complication of HIV infection or disease).

Anxiety

Anxiety often becomes a fixture in the life of the person with HIV, reflecting the chronic uncertainty associated with the infection. Some of the reasons for anxiety are given below:

- progress of health in the short and long term
- ability of loved ones and family to cope
- risk of infecting others with HIV
- social, occupational, domestic and sexual hostility and rejection
- abandonment, isolation and physical pain
- fear of dying in pain or without dignity
- loss of privacy and concern over confidentiality

Depression

Depression may arise for a number of reasons. The absence of a cure and the resulting feeling of powerlessness, loss of self esteem, the loss of personal control that may be associated with frequent medical examinations, and the knowledge that a virus has taken over one's body are all important factors. Similarly, knowing others or about others who died or are ill with HIV-related disease and experiencing such things as the loss of potential for procreating and for long term planning may contribute to depression.

SEXUALITY

Sexual behaviour change of a client is an important component of STD and HIV counselling. Unfortunately, many counsellors find it difficult to get over being shy, embarrassed and put off dealing with the sexual issue; at other times, they are judgmental and label a sexual behaviour as not normal. Counsellors will essentialy the need 4 C's - Compassion, Care, Communication and Counselling, in order to achieve success in this arena. It is also important to have a basic knowledge of sexuality and the range of sexual behaviours.

What is Sexuality?

Sexuality is a complex phenomenon which is difficult to define but perhaps easy to understand. Sexuality refers to the total sexual makeup of an individual. It is expressed in many physical ways. It is not confined to sexual intercourse but includes touching, talking, embracing, fantasizing, kissing, caressing or just holding hands. In addition to covering the physical aspects, sexuality also encompasses feelings, attitudes, values and preferences. It involves a lot of caring and sharing. Understanding sexuality is important for safer sex behaviour.

What Exactly is Normal?

Today it is recognised that there are many variations of sexual behaviour. No two people have the same sexual behaviour. On the other hand, we all like to think that our thoughts and actions regarding sex are "normal". In reality, our thinking has been conditioned by culture, tradition, society and our own emotions and experiences. An appropriate example is of homosexuality. A range of responses are expressed by different people about this: "They are unnatural"; "Should not be tolerated"; "It is abnormal"; "If found in a work place, they should be ostracised or sacked"; "It is an alternative sexual behaviour and homosexuals are as good as heterosexuals". Whatever may be the beliefs or personal views, counsellors must be non-judgmental in viewing the client as a person requiring compassion, care and help to practice safer sex rather than concentrating on changing the sexual orientation.

Sexual Preferences/Orientations

One of the sexual characteristics of humans is the preference for certain kinds of partners or sexual activities. Although there are common patterns which we share with each other, each individual is probably unique in his/her pattern of preferences. Fundamental to our sexual lives is the gender and type of person we are attracted to because this plays a large part in determining our intimate relationships, i.e. are we attracted to someone of the same or opposite sex, (are our preferences predominantly homosexual, heterosexual or bisexual)?

(a) Heterosexuality :

Persons who are attracted to and choose to share their bodies sexually with persons of the opposite gender only, are called hetereosexuals.(i.e. man-woman relationships) Generally speaking these male-female relationships are more common among people. In the context of HIV/AIDS, the spread of HIV infection is highest among the heterosexual group

(b) Homosexuality :

Persons who feel attracted to or choose to share their bodies sexually with persons of the same gender are called homosexuals. In a male-male relationship, the person may be termed "homo-phile" or "gay". In a female-female relationship the person is known as a "lesbian". The reason why homosexual behaviour is preferred by some is still debated. The term "alternative sexuality" is becoming a more acceptable term to refer to preference of one's own gender group in intimate relationships. Attitudes towards homosexuality are changing although there is still a great deal of antagonism, contempt, anger and misunderstanding among people. Health professionals are now coming to accept homosexuality more as a sexual variation than as an illness. Sometimes, homosexual experiences may be situational as occurs in prisons, some boarding schools and colleges. The person may participate voluntarily or be forced even when he/she usually prefers heterosexual intercourse. Studies also suggest that in India homosexuals sometimes maintain a bisexual existence.In order to ensure social acceptance, people project a heterosexual nature while carrying on homosexual activity away from the public eye. .

(c) Bisexuality

Bisexuals are persons who frequently indulge in both homosexual and heterosexual experiences, namely they are persons who are sexually attracted to or have intercourse with both males and females. A number of homosexuals are unable to stand upto societal disapproval or family pressure for marraige and may get married, thus entering a bisexual role. Studies also suggest that homosexuals in India sometimes maintain a bisexual existence, in that the heterosexual side being their public side so as to ensure social acceptance. This group is very important and needs attention' keeping in view the trend of HIV transmission in India which is moving from heterosexuals to homosexuals.

Role of Love and Emotions in Sexuality

Different people have different motivations for wanting and engaging in sexual intercourse. It is important to view sex as an activity that human beings choose in order to fulfill a need (could be physical, emotional, romantic, economic). Emotions, in particular, play a very important role in sexual behaviour. "Being in love" or "feeling attracted" to someone increases one's desire for sexual intimacy and may override logical and rational thoughts or even cultural taboos. Thus, in the context of HIV/AIDS it is essential to examine meaning and value that sex holds in a person's life only then can one offer suggestions or give guidance that would be realistic in and respectful of the individual's life.

We cannot afford to treat sex as an isolated, antiseptic or mechanical activity when advocating safer sex practices and risk reduction behaviour. Reasons for having sex vary with age, gender, societal norms and educational levels. In the younger age group, when romanticism and awakening attraction to the opposite sex are at a peak, "being in love", "exploring and experimenting" and "emotional needs" are the primary reasons for having intercourse.

There are some differences between men and women too. Most women want the sexual experience to be an emotional as well as a physical bond. Women tend to perceive sex not merely as brief genital contact, pleasurable though it may be, but also as sharing an emotional, intimate part of each other. They engage in sex to gain happiness of sharing experiences, the fun of doing things(sexual and other) together. They believe that pleasure is obtained by giving pleasure to another.

A couple's perception sexual pleasure depends on their knowledge of the role of sex in intimacy, and the fact that pleasure can be increased by communicating their needs to each other. Some people obtain great sexual satisfaction from "pure sex", that is a sexual encounter between two people who are strongly attracted to each other physically but who have no deep emotional bond. Others reject this form of sexual pleasure, claiming that unless emotions are involved, sexual pleasure is inevitably diminished and "pure sex" can never equal "love-sex".

In "love-sex", the focus is on all kinds of erotic activities from kissing, hugging to mutual masturbation as an expression of the emotional caring and love between two people. One's attitude towards the meaning of intercourse also influences the kinds of sexual activities. If the belief is that sexual pleasure can be derived only through intercourse(coitus), it would lead to deriving pleasure from quick penetrative sex without any emotional involvement. If such a belief exists, individuals may seek sexual intercourse from CSWS quite frequently.

Counsellors need to explore with clients their feelings and needs about sex, so as to develop plans of action that are realistic and successful in terms of safer sexual behaviour. Counsellors should emphasise that sexuality is not just sexual intercourse but also includes touching, talking, embracing, fantasising, kissing, caressing or just holding hands. Counsellors could also encourage clients to strengthen their emotional bonds with their partners and not to focus on "coitus" or "pure sex".

The spectrum of sexual behaviours is wide and should be viewed in the context of culture. Some sexual behaviours in the context of STDs and HIV/AIDS are mentioned below:

Abstinence

This refers to the act of keeping away from sex. Culturally, in India, a number of young people believe that sexual intercourse should only be done after marriage. Virginity is till prized. While recommending safe sex, those wishing to practice abstinence should be encouraged. In India it is also seen that the sex life of the married couple is often controlled by several outside forces.

Ideas of auspicious and inauspicious days, and long periods of abstinence after child birth etc. minimizes the number of days when the husband and wife can be sexually active. Other periods when sexual abstinence is considered essential, or is inevitable are during menstruation and mourning. These long periods of abstinence can lead to men indulging in sex outside marriage for e.g. going to commercial sex workers (CSWs). Thus the Counsellor must motivate the client to experiment within the marital relationship as a means of being sexually satisfied.

Masturbation

This refers to stimulating one's own genitals to reach orgasm. Most males masturbate with their hands, while some rub their penis against the surface of the bed or use some object. Females masturbate by stimulating their clitoris or vagina with their fingers. Masturbation is still taboo in India due to a majority of the beliefs related to semen and masturbation. One traditional belief propounds that one drop of semen is equal to 40 drops of blood and the loss of semen is believed to disturb the powers of concentration, leading to weakening of eyes and moral and physical power. Masturbation is reported to cause severe anxiety among men as many believe that long term masturbatory habits lead to insanity, TB, exhaustion, back aches, sunken eyes, deformity of penis and eventual impotence. It is important for the counsellor to assess and remove misconceptions and guilt regarding masturbation so that the client can see the value of masturbation as a safer sex practice.

Nocturnal Emission

Involuntary ejaculation during sleep is called Nocturnal Emission. If a male does not have any other method of sexual release, he will experience "wet dreams" or nocturnal emissions. The person will have a dream with erotic content during which ejaculation will occur. He may suffer from guilt or shame or unknown fears when such dreams occur. Misconceptions regarding nocturnal emission are similar to masturbation. Counsellors must help their male clients understand that nocturnal emissions are perfectly normal.

Oral Sex

Using the mouth in any way on portions of the body is referred to as oral sex. However, most people believe it is specifically using the mouth on the partner's genitals. "Fellatio" refers to the female using her mouth on the partner's genitals. Cunnilingus is when the male uses his mouth to stimulate the female's vagina. Oral sex should be avoided in cases where HIV infection is a possiblity or other infections/ulcers are present in the mouth. The male should wear a condom while engaging in fellatio. Studies show that some men like to experiment with different postures for intercourse or different types of sex including oral sex. However they may refuse this form of sex with their wives. Such men may therefore, look to relationships outside marriage for sexual variation, and may even approach CSWs. This behaviour will have implications on HIV/AIDS transmission.

Anal Sex

In anal sex/intercourse, the male inserts his penis into the anal canal (rectum) of his female/male sexual partner. The female may at times insert a finger or a similar object into the rectum of her partner. During anal intercourse the woman does not usually reach orgasm but the man usually climaxes. Anal intercourse is considered a very risky behaviour, in the context of HIV/AIDS. This is because the rectum is small and not as elastic as the vagina; and there is no natural lubrication or secretion. The lining of the anal canal can easily rupture/crack during penetration leading to bleeding. Similarly the skin of the penis can get affected/torn. This can result in intermixing of semen/seminal fluids and blood (exchange of body fluids) and it leads to an increased risk of HIV transmission if one of the partners is infected. The risk is usually more for the receptive (whose anus is involved) partner than for the partner doing the penetration.

While it was earlier thought that only homosexual couples indulge in anal sex, incidences of anal sex have also been reported among heterosexual couples.

On Counsellors and sexuality:

A few words for counsellors on sexuality

- they should be comfortable and familiar with the terminology of human anatomy, physiology and sexual behaviour;
- they should understand the basic underlying processes of reproductive and sexual physiology;
- they need to appreciate the range and variety of sexual expression in the human culture;
- they must recognize the social implications of human sexual behaviour and the relative nature of these implications in different societies.
- they have to work at being able to deal candidly with their own sexuality in relation to oneself and others, and reflect on the related moral and ethical dilemmas.

TALKING ABOUT THE USE OF CONDOMS

The counsellor must emphasise to clients of both sexes the importance of consistent use of condoms. Even in the case of strong resistance to the use of condoms, clients must be helped to assess realistically the risks to themselves and others of not using condoms.

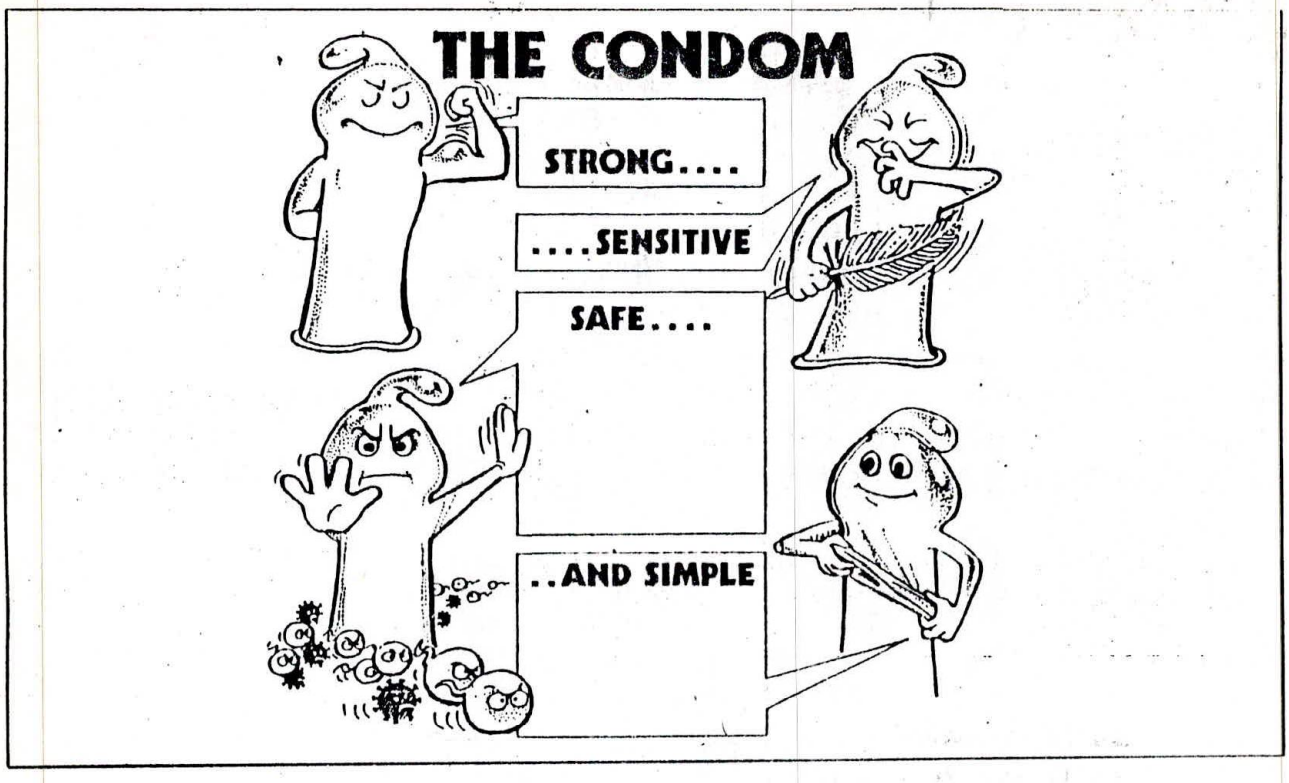
The counsellor should be forthright in telling clients that condoms need getting used to, and that they will need to practice putting them on. Clients also need to be told that condoms are not foolproof against tearing or leakage, and must be used carefully and properly.

Instructions for condom users:

For maximum protection against HIV infection, condoms must be used correctly. Make sure that you understand and follow these instructions :

- Use a new condom every time you have intercourse. Check the expiry date before use.
- Always put the condom on the erect penis before intercourse begins.
- In putting on the condom, squeeze the nipple or empty space at the end of the condom in order to remove the air. Do not pull the condom tightly against the tip of the penis; leave the small empty space (one or two 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 and use a new condom.
- After ejaculation, withdraw the penis while it is still erect. Hold the rim of the condom as you withdraw, so that the condom does not slip off.
- Remove the condom carefully so that seminal fluid does not spill out. Dispose used condoms in a closed receptacle.
- If a lubricant is desired, use a water-based one, since petroleum jelly may damage condoms.
- Do not use saliva as a lubricant - it is ineffective and may lead to breaking of the condom.
- Store condoms away from excessive heat, light, and moisture, as these cause them to deteriorate and perhaps break. Do not keep them in the glove compartment of cars or a wallet for long periods of time.
- Condoms that are sticky or brittle or otherwise damaged should not be used.

Even the well educated may find these instructions may prove difficult to follow. It is preferable that counsellors become conversant with them and then explain them in simple language. Use of simple graphic material(adapted to the culture) is recommended. Consider adapting the culturally appropriate graphics already in use by family planning associations in your area.



GUIDELINES ON TALKING ABOUT SENSITIVE TOPICS

It is necessary for counsellors to obtain an understanding, or history of the behaviour which may have exposed the client to HIV infection or AIDS. This means that counsellors must be able to gather and interpret information about very private - and sometimes illegal or socially condemned - behaviour. There is no simple formula for getting people to talk about topics such as their own sexual activities, drug injecting or responses to infection from blood transfusion. Effective discussion of sensitive topics will depend in large part upon the ability of the counsellor to:

- Gear his/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/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 towards the client. With some clients, counselling can be a process which develops gradually and may need to be eased into slowly. A rapport will need to be established, early on together with an overall atmosphere that helps the client to develop a feeling of safety and trust. Without this, the counselling process will not be completely successful. The counsellor's style must therefore be reassuring, confident and direct, but considerate of the client's feelings and fears and should acknowledge the client's difficulty.

The following guidelines on talking about sensitive topics may be useful for counsellors:

1. **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 her now?

2. **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?

3. **Anticipate a certain degree of embarrassment 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 how many sexual partners have you had over the past six months.

4. **Explain clearly why you must enquire into sexual practices and drug injecting - habits that it is in order to determine precisely what the client needs to do to prevent becoming infected or passing the infection on to another person.**
   Example: HIV is transmitted in a number of quite specific ways. You know that sharing needles is dangerous for you and for others. What can you do to keep yourself free of infection, or to protect other people?

5. **Explain the reason why you are asking questions about all forms of transmission.**
   Example: Sometimes people are offended when I ask about practices that seems strange or even repulsive because they are not common in this area. But, people travel, and sometimes experiment, so we must make sure that al the possible risks are covered.

   In such 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.

6. **Be very explicit in getting information about sexual practices**
   Question **:** What do you think people find most difficult to 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?

Question : 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? This information must be communicated in language and terms that the client understands. The counsellor will need to try different versions and will have to vary them for individual cases.

The counsellor should anticipate that some of this information may be met with embarrassment, laughter, turning away, or even anger, depending on the cultural context. For example, a person might become angry with counsellor who mentions masturbation, on religious grounds. As always, the counsellor should respect the clients beliefs. However the counsellor should point out that everyone is entitled to complete information, whether or not a decision is made to act on it.

> It is imperative that the counsellor acknowledge that changing sexual patterns or behaviour, and maintaining that change, is very difficult. Cultural expectations about sex roles and sexuality, and about childbearing, must be discussed. A suggestion about condom use which makes good sense to the counsellor may be perceived by a client as an assault on his masculinity or as a threat to the relationship with the spouse.

Suggested Readings :

Gordon, S., & Snyder, (1989) : Personal Issues in Human Sexuality : A guide for better sexual health. Boston : Allyn and Bacon.

Indian Journal of Social Work. Special Issue : Sexual behaviour and AIDS in India. Vol LV, No. 4. Bombay: Tata Institute of Social Sciences.

Kakkar Sudhir, (1989): Intimate Relations : Exploring Indian Sexuality. New Delhi : Penguin Books.

Kothari P. (1987): Common Sexual Problems. Bombay : V.R.P. Publishers

ACTIVITY 1 : Where do you stand?

Time : 30 mins

Objective :

The purpose of this activity is to make the trainees identify personal values about sex and to be able to discuss these values with others. It also gives them a chance to listen to different opinions and values from their colleagues. **There are no right or wrong answers.** The purpose is not to convince others of your values but for everyone to listen to new or different ideas.

Procedure :

Prepare two signs which say "**AGREE**" and "**DISAGREE**". Tape them on the walls on opposite sides of the room. There might not be enough time to work with all the statements listed below, so the trainer can choose those statements from **Worksheet 1** that are most relevant and/ or controversial for the group. The trainer should read each statement and ask the trainees to decide whether they agree or disagree with statements and accordingly stand near the AGREE/ DISAGREE signs. Trainees can go to the middle of the room if they are undecided. Encourage them to choose an opinion.

After you have read the first statement and the participants have moved to opposite sides of the room, ask each participant to find a partner in their side of the room. Each person explains to his/her partner why he/she agrees or disagrees with the statement. This should take about 2 minutes. There should be no discussion. The trainee should only listen to what the other person has to say. Next, ask every person to find another partner, this time from the opposite side of the room. Repeat the same procedure of sharing.

Read the next statement and repeat this procedure. You can vary the ways in which participants discuss their opinions/values with each other. For some statements, you may ask them to discuss only their values with someone or several people from the opposite sides of the room. For other statements you might ask people from both side of the room to share their views. Continue this activity till time permits. At the end, spend 5-10 minutes asking the following questions to facilitate an exploration of the impact of this activity.

Questions for Discussion

- What surprised you?
- How did you feel exposing your values to each other?
- What was it like to see that others disagree with you? How did you feel?
- How did it feel to listen to different views, without trying to change other's opinions?
- Did you change any of your views after listening to different ideas?
- How might your values and attitudes bias HIV/AIDS counselling? What can you do to keep your values from influencing HIV/AIDS counselling in a negative way?

WORK SHEET 1

Statements about sex

A) Parents should not allow their daughters as much sexual freedom as they allow their sons.

B) Children should be taught about sexually transmitted diseases (STDs) and AIDS at school.

C) It is alright to have sex just for pleasure.

D) It is okay for a man to have extra marital sex.

E) It is acceptable for a woman to have premarital sex.

F) People who have HIV infection should not have sex.

G) It is more important for a man to be sexually satisfied than a woman.

H) Parents should discuss safe sexual practices with their teenage children.

I) If a wife wants to use a condom for HIV prevention, but her husband does not, then the wife has a right to refuse sex with her husband.

J) It is alright for men to have sex with other men.

K) Talking to teenagers about sex encourages them to practice sex.

L) It is alright for parents to allow their sons to practice sex before they get married.

ACTIVITY 2 : Content Presentation

Time: 60 mins

Objective :

The purpose of this activity is to gain an understanding of sexuality and the psychological issues in relation to HIV/AIDS.

Procedure :

The trainer highlights the issues brought out in the content section of this module so that trainees have a better idea of sexuality and the psychological issues in relation to HIV/AIDS.

ACTIVITY 3 : Fear, Stigma and Stress

Time : 60 mins

Materials : Flip charts and pens - Prepare a page on the flip chart by dividing it; into 3 columns as follows: ***WORDS, FEELINGS, ACTIONS.***

Objective:

The purpose of this activity is to let the participants experience the fear, stigma and stress associated with HIV/AIDS.

Procedure :

Divide participants into pairs with each person in the pair designated "A" and "B"." A" explains to "B" that the results of a recent blood test reveal that "B" is HIV positive. "B" then puts into words all his or her fears about this news. A should encourage "B" by repeatedly saying "Tell me more about that' OR "What else do you fear?". After 10 minutes "A" and "B" reverse roles and repeat the above procedure with "B" explaining the blood test results to "A" for 10 minutes again.

Bring the full group together and ask group members to call out the feelings that were expressed. Write the results shared by the participants under the headings fear, stigma and stress on the flip charts for people to see.

In pairs again, "A" who is a boss, says to "B" an employee : "There are rumours going around at work that you are HIV positive. Is it true?" "A" should be instructed to be persistent for information and "B" should try to explain it away. Reverse roles after 10 minutes.

Discuss this second role playing scenario with the full group in terms of:

- What fears emerged?
- How would you feel to hear that your colleagues and friends were talking about you in that way?

Next, ask the group to call out things that are said about people with HIV/AIDS. Write the responses up on the prepared flipchart, under **WORDS**. Then ask how people with HIV/AIDS feel when they read or hear these things. Write the responses on the flipchart under **FEELINGS**. Encourage feelings to emerge. Finally ask participants how people act out these feelings. Write up the actions called out by participants on the flipchart under **ACTIONS**. Trainer must discuss that, following these actions, newspapers make their reports sensational and scandalous. Thus we have the vicious cycle of **STIGMATIZATION**.

ACTIVITY 4 : Small Group Work: Sexual terminology

Time : 30 mins

Objective :

This session is designed to help the counsellor - trainees practice talking about sex and sexual terminology, and to have trainees feel more comfortable referring to sexual activities.

Procedure:

Divide trainees into small groups of 4-6 people. Distribute **Worksheet 2**. Ask each group to come up with acceptable and slang terms for each of the given terms in English and/or their local language. After 15-20, minutes have the trainees re-assemble as a full group. Ask each group member to read out one word from their group's list for the large group to hear. By practicing this skill of using acceptable sexual terms, they will reduce possible, future difficulties in talking to clients about sexual behaviours. Wrap up this session by stating that a good counsellor should be able to select the "acceptable category" words to refer to any of these sexual terms without offending the clients, and without feeling too uncomfortable.

WORK SHEET 2

Sexual Terminology

Technical English	Acceptable terms English/Local language	Slang/ Colloquial words
1. Sexual intercourse		
2. Semen		
3. Ejaculation		
4. Penis		
5. Vagina		
6. Masturbation		
7. Orgasm		
8. Breasts		
9. Anal intercourse		
10. Kissing		
11. Oral sex		
12. Erection		
13. Buttocks		
14. Condom		
15. Homosexual		

ACTIVITY 5 : Paired Exercise: Developing Communication Skills to Discuss Sensitive Issues Related to Sexuality

Time : 30 MINS

Objective :

This activity builds skills among trainees for discussing sensitive issues and increases their awareness of the associated discomforts.

Procedure :

The trainer starts by asking the group for examples of sensitive issues. Then he/she divides the group into pairs and explains the activity:

"One of the pair will act as counsellor and the other as client. 'Chits' or small pieces of paper will be passed to the 'client' in each pair containing the description of a sensitive counselling scenario. The counsellor should try to help the client with his/her concern or dilemma".

Use one of the scenarios listed below and begin the activity. After 10 minutes, the full group re-assembles and each of the counsellors and then the clients, share their experience (feelings and thoughts) with the group. The trainer concludes the session by using **OHP #1** and going over the five guidelines listed.

COUNSELLING SCENARIOS :

- ❑ I suspect my girl friend also has other boy friends but I love her. I am afraid of AIDS and when I ask her abourt other boys she gets very angry and tells me I do not trust her. What can I say the next time I see her?
- ❑ Besides my wife, I have a regular girl friend. I always use a condom to avoid a pregnancy but she insists I should not use a condom during her menstruation period as it is a safe period. What shall I do?
- ❑ I think that my son is using drugs, but he has not talked to me about it yet. Should I bring it up?
- ❑ My wife and I have occasional anal sex and have been doing this for years. I was recently told that I can get AIDS - I am now afraid and have come to you for advice.
- ❑ I am afraid of oral sex. Is it bad? Am I in danger of infection, particularly AIDS?
- ❑ I am 17-year old boy. I have a boy friend with whom I regularly have anal sex. I do not want to stop but I am worried it may not be healthy for me.

OHP # 1

GUIDELINES ON TALKING ABOUT SENSITIVE TOPICS

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

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

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

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

5. Explain why you are asking questions about all the forms of transmission (viz. you are making sure that all possible risks are covered).

ACTIVITY 6 : Brainstorming : Safer sex

Time : 30 mins

Objective:

This activity shows trainees how to identify behaviours with clients that will reduce their exposure to risk of HIV transmission.

Procedure:

The trainer draws a line down the middle of a large sheet of paper or board and heads one side as "Good things" and the other side as "Bad things" as shown below:

GOOD THINGS	BAD THINGS

The group offer their ideas about good things one enjoys/likes and bad things or the negatives about sex. Once the paper or board is full, the trainer brings the group around to considering ways/behaviours by which the good things of sex can be kept and the bad things (risks) avoided or reduced.

The trainer also encourages the group to focus on the trainee's perception about emotions (love, desire etc) being the good/bad parts of intercourse. He/she asks trainees to summarize the major points that have been shared. **OHP # 2** is shown to highlight safer sex options as the conclusion of the activity.

ACTIVITY 7 : Game and Demonstration : Correct Condom Use

Time : 45 mins

Materials : Comdoms, penis models/bananas/bottles and tissue paper.

Objective :

This activity aims to make all trainees more experienced at discussing and demonstrating condom use.

Procedure :

Each trainee needs a condom for this next part of the activity. Ask all trainees to open the condom packet and handle the condom. Some trainees can try to inflate the condom. They should all stretch the condom to see how strong the condom is. Make copies of the condom cards for each group and mix them up. Handout a set of the condom cards to the subgroups of 3 trainees. Ask the group to put the cards in order.

After 5-10 minutes, the trainer demonstrates how to use a condom using a penis model, bottle or banana. State the steps as you carry out the demonstration. The trainees should correct any mistakes in the order/sequencing of their cards. Then distribute condoms, models and tissue paper (for wiping lubricant off fingers) to all the trainees. Each trainee should act out teaching one of the group members how to use the condom while the other monitors (by silently reading the cards) in pairs. Each should take a turn. Then discuss how they feel about teaching condom use. In what situations might they/might they not be comfortable teaching how to use a condom? What prevents or makes people reluctant to use condoms?

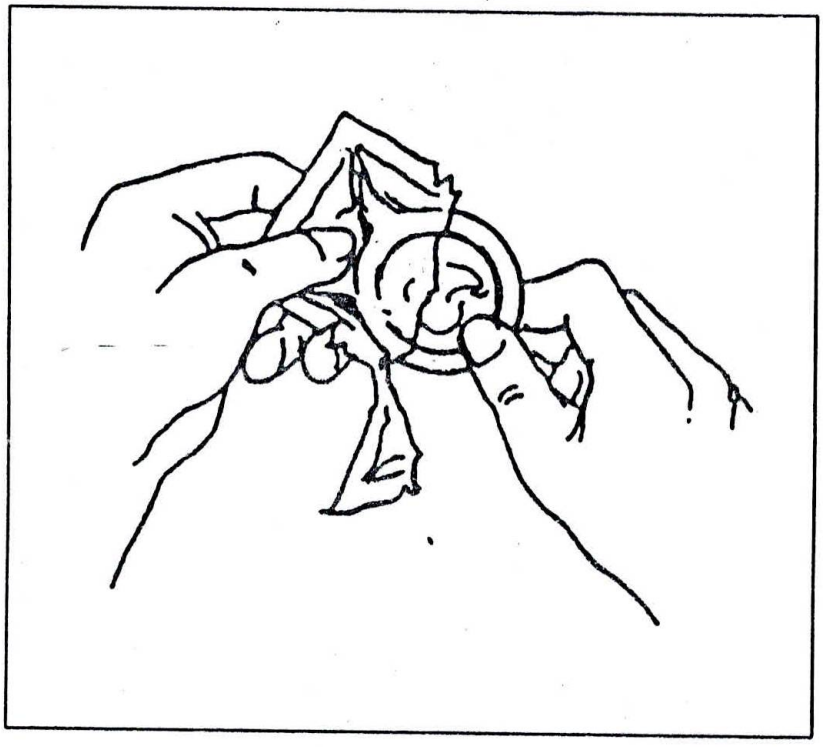
ACTIVITY 8: REVIEW QUESTIONS

Time : 10 mins

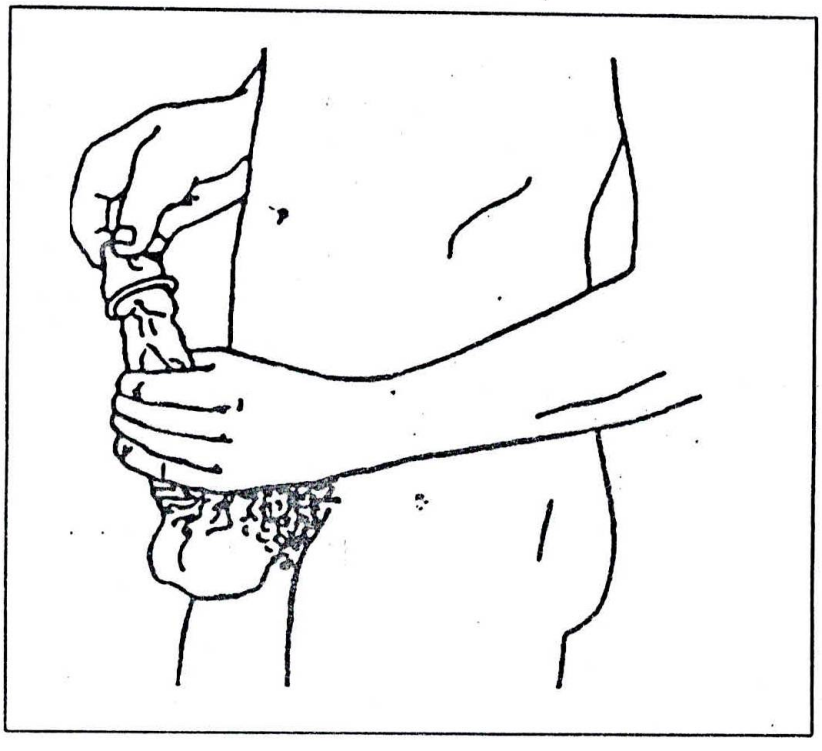
Trainees fill up **Worksheet-3** within 10 minutes. Trainees can discuss their answers with a partner or with the trainer.

WORK SHEET 3

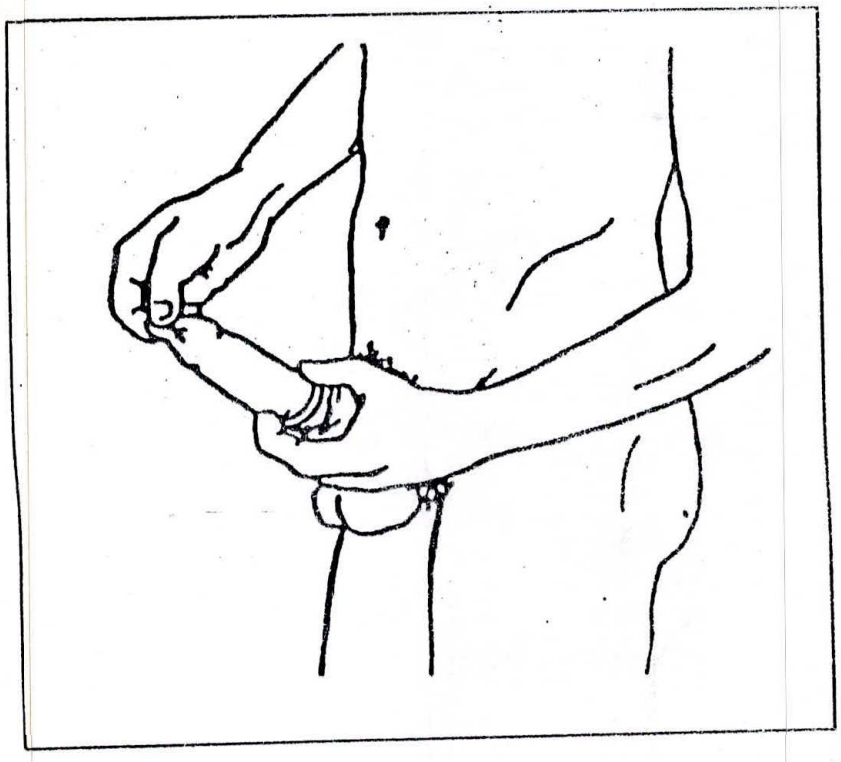
Condom use cards



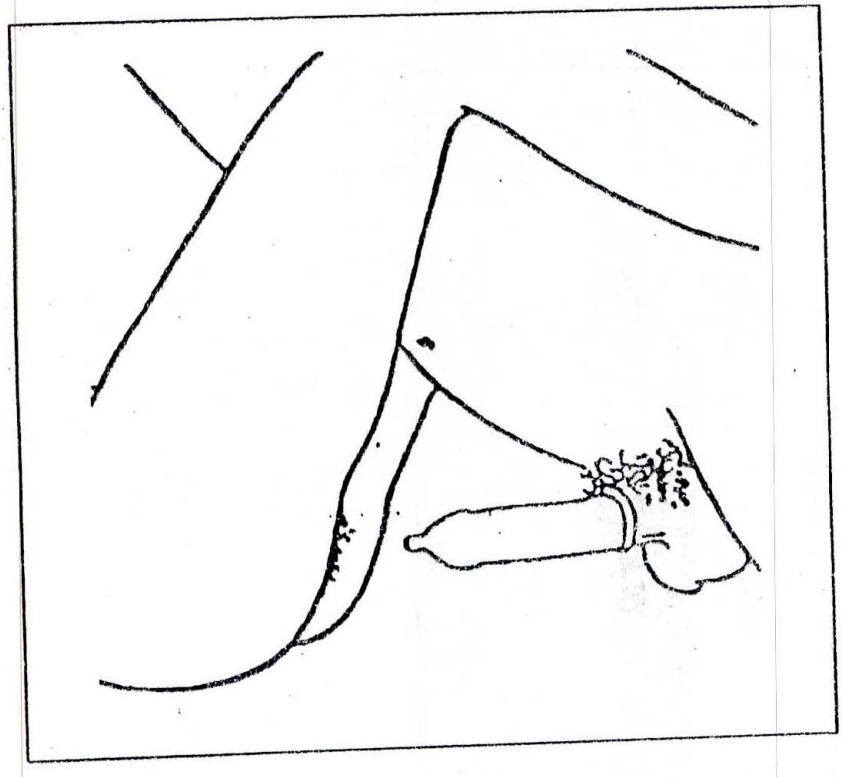
Carefully open the package so that the condom does not tear. Do not unroll the condom before putting it on.



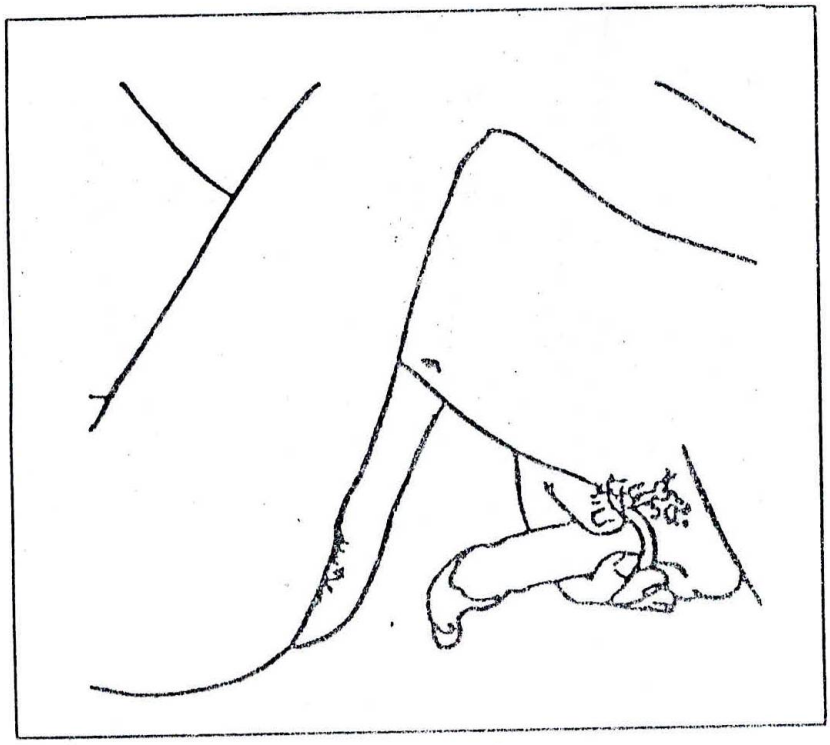
If not circumcised, pull the foreskin back. Squeeze the tip of the condom and put it on the end of the erect penis.



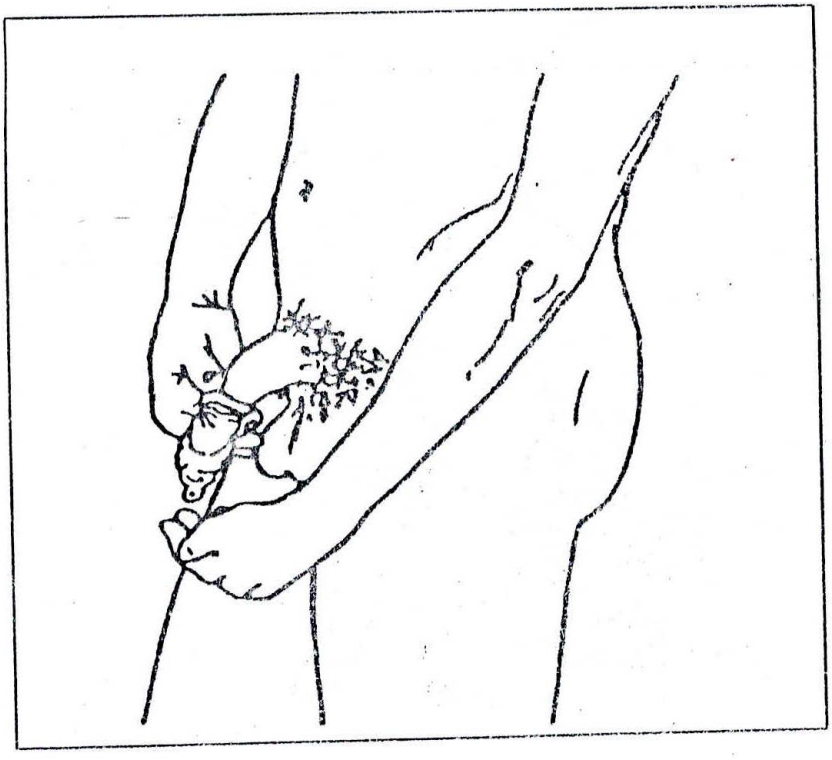
Continue squeezing the tip of the condom while unrolling, until it covers the entire penis.



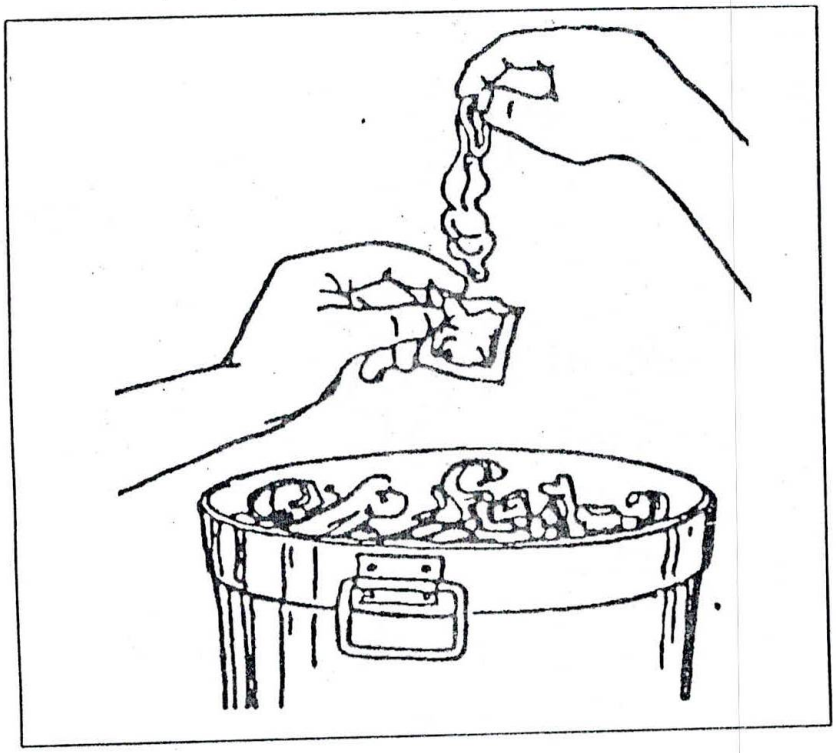
Always put on a condom before entering your partner.



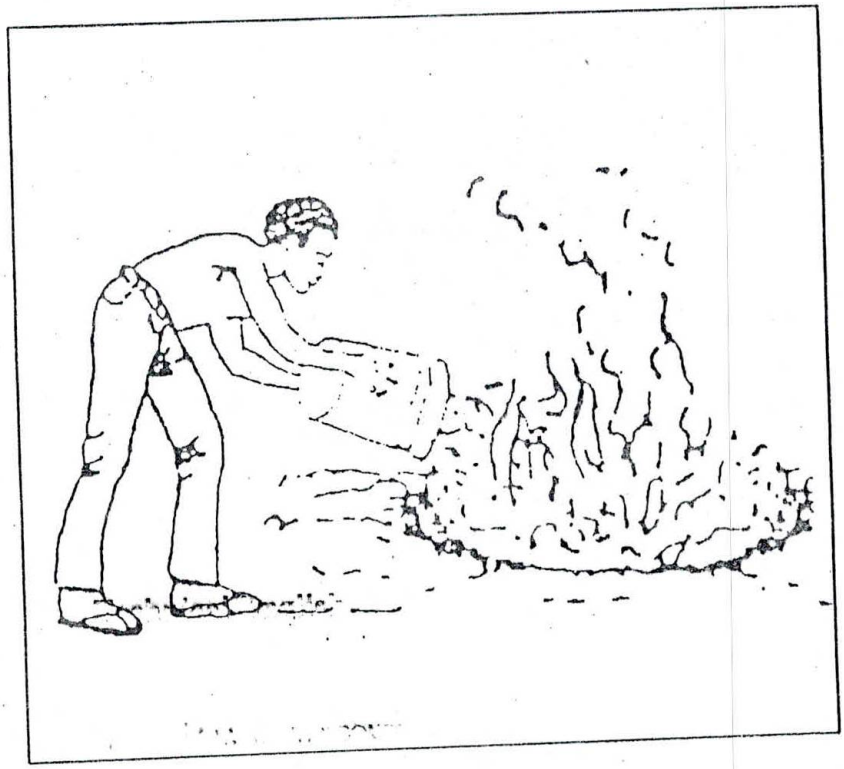
After ejaculation, hold rim of the condom and pull penis out with condom before loosing erection.



Slide condom off without spilling the semen inside.



Tie and wrap the condom (in paper), then throw in a dust bin. Wash hands.



Burn or bury the condom with other trash. Wash hands.

OHP # 2

SAFER SEXUAL ACTIVITIES

Talking, writing or reading about sex

Watching sexy films and live shows

Individual masturbation

Deep kissing

Mutual masturbation

Sex with underclothes on

Sex with other parts of the body (e.g., thighs, breasts)

Penetrative, oral, vaginal and anal sex using condoms

WORK SHEET 4

Review Questions

1. In your own work place or community, which of the high risk practices would be most difficult to talk about?

2. Explain the following terms:
   Bisexual

   Masturbation

   Non-judgmental attitude

3. How comfortable will you feel discussing the sexual behaviour of your client if he/she is of the same sex? (please circle one)

   Very comfortable Comfortable
   Uncomfortable Very uncomfortable

4. How comfortable will you feel discussing sexual behaviour if your client is of the opposite sex? (please circle one)

   Very comfortable Comfortable
   Uncomfortable Very uncomfortable

MODULE 5
SPECIAL ISSUES

EXPECTED OUTCOME

Trainees will become aware of the special counselling needs of substance users, women, children and individuals involved in non-heterosexual relationships.

MODULE AT A GLANCE
TOTAL TIME - 3 HRS 35 MINS

CONTENT SECTION

SUBSTANCE ABUSE IN INDIA
WOMEN
CHILDREN
NON-HETEROSEXUAL RELATIONSHIPS

ACTIVITY SECTION

GROUP DISCUSSION	:	40 mins
DEMONSTRATION	:	15 mins
ROLE PLAY	:	45 mins
ROLE PLAY	:	45 mins
QUESTIONNAIRE	:	50 mins
REVIEW QUESTIONS	:	20 mins

OVERVIEW

In most countries substance abuse plays a major role in the spread of HIV. Prevention efforts must target not only people who use intravenous drugs and their sexual partners, but also people who abuse other substances including alcohol. The use of substances by any individual, must be reviewed in the context of HIV/AIDS prevention. The importance of avoiding sharing needles, syringes and other injecting equipment should be emphasised. The use of bleach to sterilise injecting equipment should also be explained.

Women with HIV-infection are at particular risk of social isolation in their families and communities. The support and assistance needed by these women in re-establishing social networks wherever possible is very important. The decision to undergo HIV testing is quite often in relation to a woman's desire for, or in response to, pregnancy. Decision making about pregnancy will be an important part of counselling women, as they re-consider their lives in terms of HIV-infection.

The counsellor must ensure that, the woman being counselled understands what specific factors within her own life constitute a risk for HIV infection or re-infection. She must understand that seronegative women, like seronegative men, should be assisted to understand what choices they have in behaving responsibily to protect their own and others' health.

HIV infection in infants and children requires a great deal of knowledge, stamina, and sensitivity on the part of the counsellor. Parents and those taking care have to be given consistent emotional support and information to enable them to provide adequate care. Counsellors should be sensitive to the fact that infected children and their families may experience discrimination. This means that the counsellors must provide strong emotional support to children and their families and try to educate teachers, other parents and other health workers.

Counsellors need to be aware of special counselling needs of individuals in non-heterosexuals relationships. Sexual preferences of some people which may be socially unacceptable at present in India need to be considered; Eunuchs, Homosexuals and Bisexuals.

SUBSTANCE ABUSE AND AIDS IN INDIA

The problem of Intravenous Drug Users (IVDUs) was not considered seriously one in India, except in certain pockets. It is reported that in the North-Eastern states like Manipur, Nagaland, Mizoram and Assam where the percentage of drug users itself is high, intravenous drug use is wide spread. In most cases needles are shared and are seldom washed prior to sharing or are washed using plain water.

Studies indicate that IVDU is more common than believed in metropolitan regions and smaller towns. Thus, prevention efforts are a must in view of the sharp increase in the proportion of IVDUs among those infected. Since transmission rate after exposure to infected blood is very high (90% or higher) and since there is multiplicity of high risk behaviour namely, lmultiple sexual partners and alcohol abuse, this adds to the vulnerability of the IDVUs to infection. It is estimated that this group is the most vulnerable to infection in India. Currently only 13.45% of those who are HIV positive in the country (statistics upto 31st March 1994) are IVDUs. In terms of sheer numbers, the figure is staggering, and is poised to rise steeply.

Prevention efforts must target not only people who use intravenous drugs, and their sexual partners, but also people who abuse other substances such as alcohol. The use of substances by any individual, must be reviewed in the context of HIV prevention. Some examples of substances that are abused are alcohol, marijuana, smack, heroin, opium etc. HIV infection can be transmitted in substance abusers in the following ways:

- **Direct transmission** : sharing of hypodermic needles, syringes and other equipment.
- **Sexual transmission** : intravenous drug users can transmit HIV to sexual partners.
- **Perinatal transmission** : women who are intravenous drug users or are sexual partners of ntravenous drug users and are infected with HIV can transmit the virus to the child.
- **Suppression of the immune system** : drug and alcohol use compromises the immune system and increases a person's susceptibility to HIV infection. This may also increase the speed of disease progression once a person is infected with HIV.
- **Impaired judgement** : use of alcohol and drugs reduces inhibitions and decreases the likelihood of a person practicing safer sex and/or using condoms effectively.

Definition of Substance Abuse

Substance abuse includes both alcohol and drug abuse. Substance abuse is the use of substances where by the method, quantity and frequency in which it is taken leads to physical, emotional and sociological problems. Substances use becomes problematic because it interferes with a person's physical, psychological or social functioning. This might include:

- Medical problems directly related to substance use.
- Relationship and family problems.
- Depression.
- Inability to hold a job.
- Legal problems.

In general, the use of some substances like tobacco and alcohol is sanctioned in all cultures. The standards by which these substances are judged to be problematic usually differ from those used to assess substances which do not receive cultural sanctioning, for e.g. like opium, crack, coke, brownsugar etc.

Thus people using substances that do not have cultural sanction experience guilt and shame may hide their activities from family members and other people and may associate only with peers who are also addicted to these substances. Reaching out and counselling these people becomes a challenge as one has to break through a lot of secrecy and barriers.

Common Myths and Prejudices About Substance Use

- Substance users are immoral or bad people.
- Substance users cannot change their behaviour.
- There is no point in treating substance abuse for a person with AIDS.

Counsellors need to examine these myths and see if they also hold these views. This would seriously hamper reaching out and providing HIV/AIDS prevention information to clients.

RISK REDUCTION FOR IVDU'S

The counsellor must emphasise the importance of avoiding the use of drugs. The counsellor must also emphasise that if drug use cannot be avoided, then it is important to avoid injecting drugs. If the person cannot avoid the use of injecting drugs then, he/she needs to be told to avoid sharing needles, and syringes and other injecting equipment. Explain the risk of HIV transmission through sharing needles and syringes and other skin piercing instruments. Instructions on maintaining clean injecting equipment can be given as follows:

The first step is to flush the equipment several times with clean water to get rid of the blood or other debris stuck inside the equipment.

Then either:

sterilise by boiling the injecting equipment for 20 minutes

OR

use bleach in the following manner:

- A teaspoon of household bleach should be mixed with a litre of water
- Put the solution into a bowl and flush the syringe and needle with the solution twice.
- The syringe and needle should be flushed twice with water.

WOMEN

In the world, the number of women infected with HIV is growing faster than the number of men. This is due lack of education, cultural beliefs regarding the role of women within the family and society, and lack of economic power. All of the above factors influence the relative vulnerability of women and their access to means of prevention and support in the face of AIDS.

Issues which are of special concern to Indian women are discussed in this section. Women can be infected with, as well as can transmit HIV. In either case, the counsellor must clearly understand certain psychosocial and cultural issues as they have important implications for women and related issues such as childbearing.

Contraception and sexual behaviour

The counsellor should be comfortable talking frankly about contraception and HIV infection, and should not hesitate or be embarrassed in encouraging 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 in discussing very intimate matters, directly and openly. Women must not be left in doubt about how HIV is transmitted. The need to use condoms should be stressed in sexual relationships which are outside a stable, mutually faithful and monogamous relationship.

Sometimes the pressure on women to bear children and their desire to do so, may make a decision to avoid pregnancy very difficult. A decision should not be imposed and women should be told very clearly about the risks involved, and supported in making their choice. In view of the risk of perinatal transmission,it is particularly important that the HIV-infected women have access to effective methods of contraception. If contraception is desired, the counsellor should ensure that the couples are provided with information, advice, and supplies of safe, effective, and acceptable contraceptives. The counsellor should help them obtain correct medical instruction and follow-up with regard to their choice and use of contraceptives.

Many women feel that if they are sterilised or use intrauterine devices (IUDs) they are safe from HIV infection. This is incorrect. Whether or not other contraceptive methods are employed (intrauterine devices [IUD's] hormonal contraceptives, diaphragms), women should be advised that condoms should always be used whenever there is a risk of sexual transmission of HIV infection.

Usually, Indian women are uncomfortable or actually afraid of asking sexual partners to use condoms. There is also an implied lack of trust within the partnership if either starts/requests the use of a condom. The counsellor must explore this problem with the woman and support her motivation for condom use to avoid infection or transmission. It is essential that condoms are used and used properly. As in family planning and contraception, women have to take responsibility in this matter. Very often it will be the woman's job to encourage the use of the condom and dispose off the condom. It is suggested that counsellors inform women as well as men about the effective use and disposal of condoms.

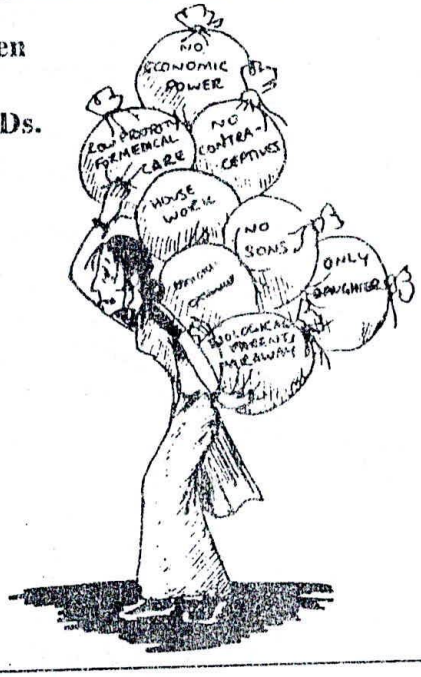
Transmission of HIV can be facilitated by the presence of genital lesions, inflammations, secretions, and scarification. The IUD has been implicated by some researchers as possibly increasing transmission. In India women often avoid seeking treatment for STDs due to the shame, stigma, fear and guilt associated with these illnesses. In regard to these conditions, women should be encouraged to provide themselves a measure of protection through seeking treatment for genital conditions, choosing appropriate birth control and avoiding sexual intercourse when genital lesions of any type are present.

> It is important that society as a whole recognize that the spread of HIV infection results from **both** male and female sexual behaviour.

In most cases, women are infected due to their partners behaviour. Historically, the focus has been on prostitution and its relationship to HIV infection. Focusing on prostitution and its relationship to HIV infection has the detrimental effect of implying that women are responsible for the spread of HIV. In addition, it draws away attention from male heterosexual behaviour. Therefore it is essential that counsellors carefully examine the sexual history of the woman-client and her partner to reduce the possibility of assuming that the fault lies with the woman.

Nevertheless, prostitution is on the list of behaviours which can lead to HIV infection. It is not prostitution per se that puts a woman at risk of HIV infection, but rather the number and types of sexual contacts as well as the risk behaviours of the partners. It is important that you as the counsellor remain non-judgmental in dealing with these women, and advocate the use of a condom for both HIV and STD prevention.

Women bear an undue burden of negative factors which increase their risk to HIV/AIDs.



Counselling women in pre-testing situations

Early counselling contacts, ideally in pre-testing, should especially focus on helping the woman feel safe in the counselling setting. As HIV counselling inevitably leads to discussion of sexuality, many women will prefer a female counsellor, at least for the discussion of intimate matters.

Information about reproduction will be part of any pre-test counselling with women, and counsellors must be clear about the facts. Testing may be a determining factor in decisions about reproduction. The counsellor must reassure a woman that it is her choice to undergo testing. An Indian woman may refuse to be tested, either because of her own or her partner's wishes, as she is viewed as the potential bearer of a son. Expectant mothers who are HIV positive or spouses of infected persons may value the pregnancy/maternity to such an extent that they insist on continuing pregnancy inspite of the HIV positive status of one of the spouses. Whatever her decision, the counsellor must try to ensure that the woman receives the best possible medical care and provide her with supportive counselling throughout.

The counsellor must provide guidance about HIV testing. Due to of the "window period", HIV antibodies may not be detectable until some months after exposure. The counsellor should take into account the "window period" and the degree of the woman's continuing exposure in considering the need for, and frequency of, repeat testing.

Counselling women about a negative test result

The counsellor should ensure that seronegative women understand that, like seronegative men, they should always act in ways to protect their own health and that of their spouse. Uninfected women, whose sexual partners are known to be infected, or at risk of becoming infected, should clearly understand how unprotected sexual intercourse with such partners puts them at risk of infection. Options for negotiating safer sex, including regular use of condoms, may be rehearsed in such circumstances. As Indian women often do not have a choice of contraception, this may be a difficult situation and so she may need the counsellor's guidance in addressing her spouse.

The positive HIV test result : Psychosocial issues for women.

Counselllors counselling women who have already tested positive for HIV or who have been diagnosed with AIDS should take into consideration how the woman has learned of her sero-status. For example, some women discover their sero-status by accident; usually after the husband or significant male partner, or the child is already symptomatic with an HIV-related disorder. The counsellor must recognize that women will be dealing with at least two crises, the crisis of her husband/partners illness or the potential or actual illness of her child as well as her own illness.

Indian women are often either unaware of their positive status or they may be the last ones in their family to know their diagnosis due to the power hierarchy in the family structure. Disclosing her infection to her sexual partner and family can be very distressing, and is likely to be an important issue in an ongoing counselling relationship.

For women, the concerns regarding HIV infection are not merely medical but also threaten her social and cultural identity. It is an unfortunate reality that when the first case is identified within the family, the blame is most often attributed to the woman, even if the evidence contradicts this. The counsellor must provide emotional support in such circumstances and also acknowledge the woman's fear that her family and friends will abandon her because of her actual or perceived past behaviour.

A single woman's seropositive state, may be the first indication which reveals to her family or intimate friends a secret life that involves activities which she has engaged in and which would be condemned by others. For a married woman her partner's infidelity may, for the first time, be made undeniable. The confrontation of these facts within the family unit may be very destructive.

HIV-infected women often feel extremely lonely and isolated. Fear of social stigma compels them to keep the condition secret. Their main fear is that of being abandoned, thereby depriving them of the support from family, friends, and community organizations. Re-establishing connections with the family and other social groups, finding substitute sources of support and examining the basis of her fears is often a major task for the counsellor.

The counsellor may help an infected woman acknowledge and talk about her feelings. Very common emotional reactions include: **anger** towards the person, usually the sexual partner, who infected her; **grief** at her loss of health and status, at a changed body image and sexuality, at the possibility of having to give up concieving children and the possibility 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.

Various forms of counselling are used with infected or ill women. Decision-making counselling may be a major focus for infected women who have children or are pregnant, as they may be too sick to fulfil their maternal responsibilities. If a child dies, they may be overwhelmed by guilt. 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 foetus to term. In many cases counselling will have to deal with cultural and religious beliefs and medical realities.

Counsellors should help women identify their existing support systems. Many women do not believe that they can get support from their families or spouses' families. Counsellors should work with clients to determine how family members can be mobilized to their aid. Educating families and communities is an effective way of aiding individual clients.

Women's peer-groups may be another 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 such meetings. There are many advantages of contact with other HIV-infected women. In cultures where support groups are rare or non-existent, the counsellor may be able to create situations which teach women to help each other through difficult times. This, in turn, could provide the basis for the formation of a group.

Self-help projects on HIV/AIDS education and support can be doubly helpful for women. It not only helps them speak publicly abut their illness and find direct avenues of support, but also helps them gain skills and confidence that come from being a recognized teacher and helper. Involvement in education and support projects also gives women a new "family" for support. It is important for HIV-positive people as well as their community to see that HIV positive people can be contributing members of the community.

Pregnancy

Women of childbearing age who are HIV infected should receive post-test counselling in order to enable them to make an informed decision about whether or not to avoid pregnancy. It is important for the counsellor to explain that HIV can be transmitted from an infected women to her foetus during pregnancy or to the infant during birth or through breast-feeding. The pregnant woman should be prepared for the possibility that the child will be born with HIV infection. However, there is at least a 70% chance of having an uninfected infant.

Currently the risk of transmission from the mother to the infant is estimated to be between 20% and 45%. The prognosis for the pregnant woman with HIV infection, in terms of disease progression, is uncertain. It is believed that in the early stages of HIV infection, 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 in later stages of HIV infection, especially when the woman has AIDS. The pregnancies in women with AIDS are more often complicated, especially by early (premature) labour, as might be expected in seriously ill or debilitated women.

When HIV infection occurs during pregnancy or when an HIV-infected woman becomes pregnant, counselling on possible courses of action during pregnancy is generally limited to compassionate support and careful discussion of possible outcomes. Infected pregnant women may require more frequent medical and psychosocial support services. A high level of psychosocial support may be necessary in cases where there are difficulties with the family during and after pregnancy.

Indian women rerely take pre-natal care. In a study conducted in 1988 by Professor Yesudian of Bombay, as many as 73% women reported that there was no need for pre-natal care. Post-natal care is better accepted than pre-natal care because it concerns the survival and welfare of the child. The counsellor should therefore insist on regular medical check-ups.

"A pregnant woman is viewed as the potential bearer of a son," - the desired sex. Her pregnancy is viewed as meaningful if it results in a son. Social status of women in India improves after birth of a son. Thus the women themselves want to have a son. The father's contribution in

determining the sex of the child is down played and the woman's fertility is evaluated negatively if the couple do not have a son. The counsellor must keep in mind the above prevalent cultural attitude while counselling pregnant HIV positive women.

While the tragedy of a child born with HIV is compelling, women's decisions must be placed in the larger context. Studies and interviews show that many women, will often choose the risk of bearing an HIV-positive child. Even where women first learned of their sero-status during pregnancy and aborted, many chose to carry subsequent pregnancies to term. While it is extremely important for counsellors to help women and their male partners assess the risks of giving birth to an infected child, it is equally important to help the woman or the couple to find other means of feeling socially valuable or productive and improving their sense of selfworth and purpose in life.

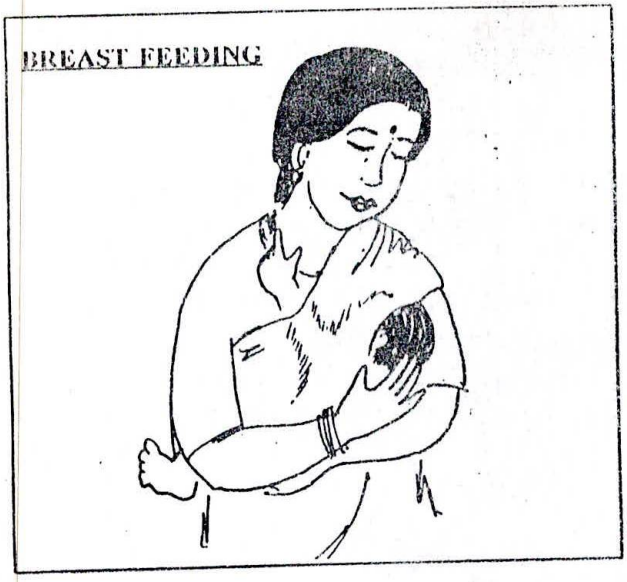
Another problem that exists in India is that of illegal abortions. These are still practised in the case of unwed mothers and those women who are unaware/embarrassed to use proper medical facilities. It is possible that HIV positive expectant mothers may avail of these facilities to abort the foetus, but hide their own HIV status. Other complications may set in if HIV positive mothers resort to illegal abortions, as such abortions are not likely to take infection control into consideration. The counsellor must help, encourage women to avail of medical facilities.

Given that many women will chose to bear children and that this will be seen as a positive contribution to her family and community, counsellors should help the woman develop a plan of 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.

The husbands or partners of HIV-infected women should be included in counselling sessions. Whenever decisions about avoiding or terminating a pregnancy or about preparing for a possibly infected infant need to be made, they should involve both the potential parents. The social and psychological support the woman will need is likely to be best assured if she gets the cooperation of her partner. Thus, counsellors should make serious and active efforts to involve and reach out to the woman's partner/spouse.

Breast-feeding

Most cases of the mother-to-infant transmission occur during pregnancy and delivery, although recent data confirms that some of them occur through breast-feeding also. Fortunately, the vast majority of babies breast-fed by HIV infected mothers do not become infected through breast milk. Recent evidence suggests that the risk of HIV transmission through breast-feeding; (a) is substantial among women who become infected during the breast-feeding period; and (b) is lower among women already infected at the time of delivery. However, further research is needed to quantify the risk of HIV transmission through breast-feeding and to determine the associated risk factors in both these circumstances.



Breast-feeding is a crucial element of child survival. A baby's risk of dying of AIDS through breast-feeding must be balanced against its risk of dying of other causes if not breast-fed. Breast milk provides an infant with essential ingredients that build up his/her immunity against future diseases. It is recommended that in countries or areas where infectious diseases and malnutrition are the main cause of infant deaths and the infant mortality rate is high, breast-feeding should be encouraged among pregnant women, including those who are HIV-infected. This is because their baby's risk of getting HIV infection through breast milk is likely to be lower than its risk of death from other causes, if it is not breast-fed. Women who know they are HIV-infected and for whom alternative feeding (formula milk) might be an affordable option, should seek advice of their health care providers in deciding how to feed their infants.

On the other hand, in settings where the main cause of death during infancy is not infectious diseases and the infant mortality rate is low, the general consensus is that the advice to pregnant women known to be infected with HIV should be to use a safe feeding alternative for their baby rather than breast-feed.

Women and Risk Reduction

The issue for women, as for men, is clearly a survival issue. In order to survive, individuals will need to know that they are at risk and that they have a choice. The first choice is being able to say "no" to high risk behaviours. To make this possible, it is essential to empower the women.

The empowerment of the Indian woman, in situations where she is dependant on others for food and shelter and in which it is the male partner who completely controls the sexual interaction, is very difficult. The choices available to her to prevent infection or once she becomes infected are limited. Thereby, she is at much greater risk of all the medical and social complications which may affect HIV/AIDS infection. In the reduction of risk practices in relation to HIV/AIDS abstinence, faithfulness and the use of condom have become the mainstay of protection for all sexually active individuals. However, in the case of women, this involves promoting protection messages that are not under the woman's control.

The most important point about risk for all women (and men) is the fact that a woman may be at risk if her sexual partner has had unprotected sexual relations with someone at risk. In fact majority of the infected women are not infected through their own behaviour. However, they are blamed for being the source of transmission. The stigma and the discrimination associated with this disease often rests with women.

In India, as in other countries, Commercial Sex Workers (CSWs) are often singled out for special attention in the context of AIDS due to the multiplicity of their sexual contacts and high STD rates. Unfortunately this has lead to a situation where they are viewed as transmitters of HIV rather than recipients of the virus. Studies indicate that CSWs in India avoid using the existing health structures for meeting their health needs due to the harsh and inhuman treatment they receive at the hands of medical and para-medical staff. Studies also show that CSWs are unaware family planning services (except abortion). CSWs may seek treatment from quacks so as to avoid facing ridicule from medical staff. From a public health point of view, it is very difficult to discover, educate and counsel the large number of women who are at risk of acquiring infection through heterosexual intercourse. Thus, it becomes the goal of AIDS programmes to educate all women about their risk of sexually acquired AIDS, and to encourage adoption of risk-reducing sexual behaviour.

CHILDREN

HIV infection in infants and children requires a great deal of knowledge, stamina and sensitivity on the part of the counsellor. Parents and caregivers have to be given consistent emotional support and information to enable them to provide adequate care.

The counselling activities and issues include :

- Assisting parents to talk about distress and guilt at having infected their child.
- Helping parents to cope with criticism from others especially from family members.
- Repeating information about transmission, prevention and the risks of any future pregnancy.
- Managing the illness of an infant or child.
- Supporting the child so as to enable it to develop physically and socially as much as possible, given the clinical condition.
- Explaining to the parents, family, school personnel and others the minimal risk the child presents to other children and adults (i.e. reducing the possibility of the trauma of discrimination).
- Supporting parents in facing the many uncertainties about the future health and well being of their child.

There are **four** groups which have to be considered. There are specific counselling issues pertaining to each group.

1. Children most at risk of getting HIV infection.
   - (i) (a) Children in need of blood transfusions or blood products e,g, hemophiliacs, thalassemia, leukaemia, and
     (b) Children vulnerable to sexual abuse especially within the family unit (in such cases special needs to be addressed by counsellor)
   - (ii) Children in legal custody
   - (iii) Street children
   - (iv) Children in various institutions

II. Children who are HIV infected.

(i) Children infected intra-uterine

(ii) Children who are infected by shared needle use, by transfussion of blood or blood products.

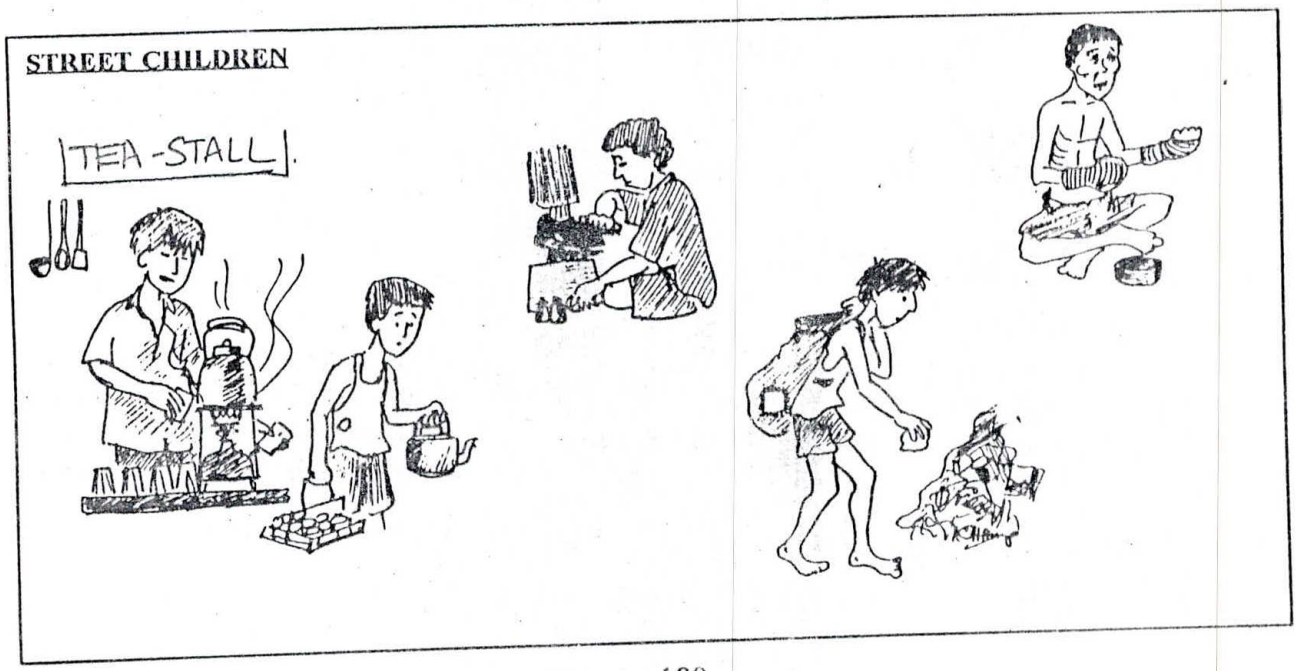
III. Children whose parents, siblings are infected.

IV. Children who are orphans (due to parents death via AIDS).

The counsellor must explain and re-explain as necessary the risks, the limitations of testing and the need for parental caution with respect to transmission. The counsellor must also stress the need to treat the potentially or actually infected infant in the same way as a normal child would be treated.

Infants with suspected HIV infection should receive as much affection and care as possible and be treated like normal infants except for being kept under medical observation. Just as with the infected adult, psycho-social support, emotional stimulation and adequate nutrition must be assured to the child This will require the counselling of parents and siblings as the infant is dependent on the adults around him/her. The counsellor may need to help parents to keep appointments at clinics and elsewhere as it is necessary to monitor and protect the child's health.

The baseline emotional and economic stability of the family, life have an impact on the care the infected child receives. The family and home life may be in deep disordered as a result of parental activities such as drug injecting or because of the illness. The counsellor must be prepared to assist the family in finding ways to ensure that the child receives proper and timely care within the extended family network or outside the family. If parents cannot provide the care required, the counsellor may then need to find substitute care. Whenever there is doubt about parental competence, the counsellor must watch over the health of both the infant and his/her parents.



The counsellor should discuss with the family members and other caregivers their concern about the risks that the infected child presents to them. In the group of "Children at risk" **street children** emerge as a group especially vulnerable to AIDS owing to their special characteristics. They are forced to seek survival on the street, which is often difficult in terms of their needs related to food, clothing, shelter, protection and social security. Some of them are engaged in economically gainful activities like working as hotel boys, coolies at the railway station, guarding and cleaning cars, selling flowers and other trivia at traffic signals, shining shoes, working in gambling dens, "wadi" work and often as ragpickers too. These activities often expose them to several health and occupational hazards for which they rarely seek care. This is partly due to ignorance and partly due to the fact that they receive indifferent attention from large public health facilities.

Sexual exploitation by older boys, men and women, in exchange for money or favours is also common. Several street children are initiated into drug and alcohol abuse at an early age and visit CSWs or take up commercial sex themselves. Street children are also known to be engaged in selling blood and organs in their struggle for survival. In the light of HIV/AIDS prevention and control, this group assumes significant importance. Fighting for survival on a day-to-day basis, they themselves are not likely to be concerned about becoming infected "sometime" in the future. This in turn may render them indifferent to preventing infection and thus be more vulnerable to HIV infection.

In some instances HIV has been transmitted to children through sexual molestation by infected adults. In cases where sexual molestation is suspected, interventions should be aggressive and investigations must be thorough. Such children of older age, must be taught assertiveness skills, concepts of privacy and the right to self determination about their bodies. They will also need help in understanding what has happened to them and coping with the subsequent fears and insecurity.

There is also special concern for children living with addicted parent(s). A parent who is an active addict has few resources available to allow effective protection or advocacy for a child. In addition to the usual issues raised when working with children having life threatening or terminal illness, many providers experience fear of contagion and may experience resentment directed at the parents for causing this suffering to their child.

Practical information about hygiene

The counsellor should discuss with family members and other caregivers their concern about the risks that the infected child presents to them. The risk is low, but care should nevertheless be taken to avoid contact with the body fluids. Caregivers should protect and cover breaks in the skin and other abrasions. Brothers and sisters and other children must be taught to avoid contact with the body fluids of the infected child/infant. Families will require practical information about hygiene. The counsellor may need to provide disinfectants and other materials or give advise on where to obtain them. The more a counsellor understands the practical problems faced by a family, the more useful and empathetic practical solutions will be offered.

A whirlpool effect is created among families as a result of HIV/AIDS whereby ramifications are dramatic. Some of the effects are :

- Siblings affected by the trauma of an ill or dying sibling. HIV negative children affected by ill or dying parents/siblings.
- Healthy children dealing with premature loss of parents to AIDS or coming to terms with parental HIV.
- Children dealing with illness (such as hemophilia, thalassemia, malaria) who have to take on the additional burden of AIDS/HIV.
- Economic hardship or deprivation as a result of economic strains brought about by caring for infected infant/parent.
- Economic hardship or deprivation due to the loss of the breadwinner.
- Economic hardship as a result of reduced income shared among greater number of family members.

Care of the HIV/AIDS diagnosed child

Psychological care of children with AIDS is of great importance. These children are suffering from a terminal illness, compounded by the fact that they may have a mother, or a father (or both) who are similarly infected. In some families, infection may extend to siblings and thus multiple problems are possible. The treatment of the child may involve repeated or constant hospitalizations, painful medical procedures and the added assaults of opportunistic infections. When faced with an unfamiliar or potentially threatening environment, many children may react adversely. Reactions differ widely and can be seen as manifestations of anxiety or fear. The anxiety has to be reduced, so that the child can be encouraged to cooperate in the treatment and medical procedures. Using approaches like play therapy or art therapy would help in reducing the fear and anxiety in children. Spending a lot of time with children is an essential element of successful counselling of children.

Younger children are particularly distressed by highly visual, short-term painful procedures - they are also more likely to see illness or surgery as punishment. Furthermore, inaccurate or incomplete understanding of bodily functions, structure and purpose may predispose children to unpleasant misconceptions about medical procedures.

Irrespective of the age of the child, the level of care offered is crucial in determining the psychological and life adjustment of the bereaved children.There is a dilemma about informing is a school setting. The parent who needs understanding and help may need to inform the educational authorities. The counselling approach to this problem must be multi-pronged. If the diagnosis of AIDS is known, the stigma may result in a child being isolated. Children of infected parents may have to drop out of school if a parent is too ill or has died

School children who have been told or already know that one of their family members is infected, may themselves need counselling. The counsellor should take great care to ensure that the type of information the children receive and the type of language used is appropriate for their ages. Children should be told that they are not at risk of catching the infection and that the

infected child should be treated in the same way as any other child at the school. Children often respond to reactions of the adults around them. So it is important for the counsellor to ensure that the children's parents and teachers are well informed. Problems arising in the school setting should be dealt with as quickly as possible to ensure that they do not gain a momentum of their own.

Stressors which are dominant in the minds of parents who have HIV/AIDS infected children in hospital are as follows :

- Fear of progressive illness.
- Fear of the child dying.
- Worry about the child experiencing pain and suffering.
- Loss of normality.
- Negative reactions of others.
- Guilt.
- Loss of control
- Changes in family structure

The child's reaction to the death of a parent may include

Shock - it can be short lived, transitory or long lasting.

Denial - the reality of a loss may be overwhelming and a child may need to deny it. Such a child will need gentle help to grasp the reality and the permanence of the loss.

Guilt - it is not uncommon for people to experience guilt feelings after a loss. These may be rationally or irrationally based. Children may feel that they were somehow responsible for a death. They may blame others such as a surviving parent or sibling.

Anger - they cannot express their feelings.

Physical symptoms - extreme grief may bring about physical symptoms such as pains, breathlessness etc.

Depression - this is not common but children tend to cope with grief by exhibiting mood swings. Anxiety leads to children feeling out of control. Facing death, they may become fearful for their lives, they may feel that their world has become unpredictable.

The counsellor must not separate the child from the parent and must ensure that, whenever possible, the child is accompanied by someone close. The counselling sessions must be frequent and short. The counsellor should make it clear to parents that it is their responsibility to inform a child who can understand information about a particular condition and what it means (e.g. why the child is coming for counselling). The child should be included in interviews with the parents and where appropriate, with grandparents or siblings. The counsellor can then observe the reactions of both the child and the family.

The counsellor should not discuss issues such as sexuality and HIV infection without parental permission as parents may object to their children learning information regarding sexuality. Older children can be seen alone or with the family. The older the child is, the closer are the reactions and management strategies used with adults. When family members hear one another's views, they may find it easier to make the necessary adjustments for supporting the child and at the same time protect themselves from infection.

Counselling extends to answering the multiple questions a child may have: Jargon free, simplistic explanations go a long way. At the same time, the counsellor must ensure that the child has a clear understanding of the explanations by paraphrasing and checking with the child. Frank and open discussions may bring relief to them. They need to be treated in an environment that allows them to ask their questions freely and allows them to trust that the response is honest. Their fears can often be enhanced if they are excluded from the discussion.

The counsellor can help the parents in their explanations to the child or the adolescent. Information and knowledge may be the only protection against discrimination such as teasing at school. Role reversal techniques can be useful with both children and parents to enable them to identify and ask the questions that they consider important, e.g. a parent can play the role of a teacher who wants to know about a child in the school with HIV infection.

It is also important to promote the child's self image and self-esteem and emphasize how well he/she is coping. In order to understand how one should talk to children about death, be it their own from illness, or that of a sibling or a parent, it is a prerequisite to have some understanding of children's concepts of death and how they accommodate these. The child's age and the support surrounding the child are two key elements in pacing the information related to death.

The child's sense of time should not be thought of in relation to an adult's. This means that a child is able to easily deal with events in the more immediate future and may find events in the distant future harder to grasp. The child must be given as much as he/she can take and should be provided the space for ongoing open dialogue.

When a child is dying, silence, denial and pretence are three factors that are often present in a child, when a child is dying. Such defenses may be props that are keeping the child together, and it is important not to destroy these without careful thought and the provision of alternatives. Counselling is not only linked to informing a child about death. The illness brings with it many fearful and perhaps painful procedures. If these procedures cannot be avoided then, the child should be prepared for them. The child may need a lot of encouragement to face up to his/her remaining life with enthusiasm. The terminal period marks the time when the death is imminent and seen as inevitable. A child may have a need to say farewell, either overtly or symbolically and this can be easily facilitated by the counsellor. This can also to apply to a child whose HIV infected parent is dying.

People long for the birth of a healthy child. 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 and counsellors must accept and support it. However they should also watch for a parent's withdrawal into chronic grief or seeming indifference and neglect of the child or other children in the family. Counsellors should encourage parents to deal with and work through their grief by talking openly about their feelings of self-blame or guilt because of their past/current risk behaviours.

NON-HETEROSEXUAL RELATIONSHIPS

It is important to note that heterosexuality is not the only accepted norm of sexuality in India. Many other variations exist and are accepted in a far better manner than in most Western societies. This may be partly due to the evidence of homosexuality, bisexuality, transvestism and hermaphroditism found in the Indian epics and ancient literature. Eunuchs and homosexuals formed part of the royal courts of many Indian kings and bisexuality was known to be common among persons of royal lineage. Folklore, myths and traditions thus encourage the acceptance of alternative forms of sexuality. In modern India, this acknowledgement however does not imply an overt acceptance of the desirability of alternative forms of sexuality.

In the context of HIV/AIDS, it is important to address the needs of people which may be socially unacceptable at present in India: for e.g. in the case of Eunuchs, Homosexuals and Bisexuals.

Hijras/Eunuchs

Eunuchs encounter more ridicule than compassionate tolerance. The term "hijra" or "chhakka" which implies incomplete sexual identity is often used derogatorily as the lowest form of abuse. Undoubtedly the world of the eunuch is private and this community strives to retain its privacy. According to studies, the eunuch is basically a castrated male. He may also be someone who feels trapped in a male body with a female sexual identity. In such an event, castration may be voluntary. At times, male homosexuals involved in passive anal sex are known to turn to this way of life due to inability to find a social position that accommodates their behaviour. At other times a child may be given away in return for a divine favour. A child with sexual or other deformities may also be given away by parents. It is not known how many children are abducted by the cult, but there is evidence to indicate that abduction is prevalent.

What is known about the practices related to castration and the healing of the wound suggests a lack of care and indifference to hygiene. In fact their health is likely to be highly neglected. Health facilities available to the general public are socially out-of-bounds for them since their image either evokes fear or contempt from people. Their sexual hygiene, practices related to castration, post castration care and sexual activity (often anal sex) are likely to make them specifically vulnerable to STD and HIV infection.

Eunuchs indulge in commercial sex as a way of earning some income. They are frequented for oral and anal sex by homosexuals or bisexuals. The clientele that approaches this group is unique as they are generally said to be middle aged men who are travelling away from home. Their clients don't want to be seen with this group and thus sex is quick and penetrative and mostly in deserted public places. As eunuchs are not the preferred choice, this group fears losing clients and thus does not insist on condoms. Eunuchs are harassed by the police and thus have to change their pick up points and therefore are difficult to track. The counsellor must understand his/her own limitations in working with this group before getting into a therapeutic relationship. This group needs non formal education, health education, empowerment as a group and information regarding legal issues. The counsellor must encourage assertiveness in the use of condoms. As eunuchs often identify with the female sex, a female counsellor may be much more effective.

Homosexuality

Homosexuality has been a taboo subject, its existence not being recognised. Till the panic about the AIDS epidemic hit India, its existence was known but not discussed. Homosexuals are a minority group who are sexually attracted to members of their own sex. A common myth prevalent in India is that homosexuality in an abnormal condition and people who are practicing it should be treated and cured of it.

In the metropolitan cities, especially Bombay and Delhi, several prominent personalities openly acknowledge their gay identity. The majority continue to hide their true sexual preference, by adopting bisexuality and even marrying under high parental pressure or to ensure social conformity. There is an added risk of HIV infection to the male partners and spouses of married homosexual/bisexual men.

The vulnerability of this segment to HIV infection is high due to lack of information and due to denial of the risk when information exists. Sexual practices among homosexuals preclude the use of condoms as condoms are associated with birth control. Sexual contacts are often short-lived and anonymous, though long-term relationships which under-emphasise the sexual aspect do exist. High sexual activity and multiplicity of sexual partners also characterise homosexual relationships. The possibility of negotiating condom usage or actually using the condom are thus low. Distrust towards the heterosexual community, is partly due to fear of their reaction to homosexuality. The homosexuals are thus often suspicious and unwilling to listen. If at all, it would be to members of their own community. The counsellor has to be sensitive to the fears of this community and should have a non-judgmental attitude towards them. Counselling must cover issues related to health information, counselling on AIDS and condom usage.

This group identifies with men. They would thus be more comfortable with a counsellor of similar sexual preference. The counsellor needs to be empathetic and understanding towards the needs of this group. Counsellor must also emphasize the need for negotiating long term emotionally stable relationships among this group. Usually members of this group get involved with a mate for sexual purposes before getting into an emotionally satisfying relationship. Counsellor must also cover issues regarding health and hygiene, STD control and the importance of a homosexual being comfortable with his own sexuality.

Bisexuals

These individuals are heterosexuals by nature but adopt occasional, homosexual liaisons due to non-availability of alternatives or as a convenience, for e.g. prisoners, young men in hostels or male dormitories and men who live away from their wives in collectivity. Others may adopt the bisexual way of life since it camouflages their true preference for homosexuality. Others may be coerced into homosexuality, for e.g. young boys in hostels, prisoners or truck cleaners. This group is likely to be more deprived of information and may actively avoid any exposure to information as it implies an acknowledgement of their sexual activity. Lack of education and other features of socio-economic marginalisation may act as further disadvantages for this group.

In India this group is very important in the context of HIV transmission as the trend is from heterosexuals to homosexuals. There is a risk HIV transmission to the male partners and spouses of married bisexual men. The counsellor needs to deal with denial which is greatest in this group. This group is difficult to detect as they cling to their denial and as a result, deny high risk behaviour. Another feature that may be seen in this group is lack of long term relationships with their sexual partners. The sexual encounters are often sudden and not planned for and this leads to low condom usage. The counsellor needs to address issues regarding Health education and condom usage.

Suggested Readings :

Mane P. & Maitra. S. (1992): AIDS Prevention. Bombay : Tata Institue of Social Sciences.

Plant M.A. editor, (1990) : AIDS, Drugs and Prostitution

Ramchandran P. (1992) : Women's Vulnerability. Seminar 396 p. 21-25.

Selwyn A.P. : Injecting Drug use and HIV infection. Geneva: WHO

UNDP HIV and Development Programme Publication: Young women : Silence, susceptibility and the HIV epidemic.

ACTIVITY 1: Group Discussion : What do I believe and feel about Substance abuse?

Time: 40 mins.

Materials: Large sheets of paper, pens, markers or coloured chalk.

Objective:

The purpose of this activity is to understand and discuss personal attitudes and cultural beliefs and attitudes about substance abuse.

Procedure:

Divide the large group into small groups of six people each. On three large sheets of paper, write the following headings?

ALCOHOL	INTRAVENOUS DRUGS	NON-INTRAVENOUS DRUGS

Ask the groups to brainstorm all the words they can think of which describe, people who use or abuse alcohol, intravenous drugs or other drugs. The list should include common names or slang terms, beliefs and attitudes. Within each category, ask trainees to discuss specific drugs or liquors separately. After 15 minutes, ask the groups to move on to the following questions:

- What does the list suggest about general cultural responses to:

  1. alcohol use and abuse?
  2. intravenous drugs and abuse?
  3. non-intravenous drugs and abuse?

- What are your personal responses to the above?

In processing the responses, trainees should be asked to consider how cultural attitudes and values toward substance users might effect AIDS prevention efforts and how their personal views might affect their work as prevention counsellors.

ACTIVITY 2: DEMONSTRATION OF THE USE OF BLEACH

Time: 15 mins

Material: A packet of bleach, one litre container, a teaspoon, a syringe and needle, a bowl of water.

Objective:

This activity aims to teach all the trainees the correct use of bleach to disinfect needles and syringes and other injecting equipment.

Procedure:

The trainer demonstrates the preparation of the solution of bleach and demonstrates how to flush the syringe and needle first with the bleach solution and then with water. The first step is to flush the equipment several times with clean water so as to demonstratew to the trainees the way to get rid of blood or any other debris stuck inside the equipment.

Then take a teaspoon of bleach and mix it with a litre water, put the solution into the container and flush the syringe and needle with the solution twice. The syringe and needle should be flushed then twice with water.The trainer also explains the option of sterilisation of syringes by boiling them for 20 minutes.

ACTIVITY 3: Role Play - HIV infected single mother with small child.

Time: 45 mins.

Objective:

The purpose of this activity is to address some of the counselling issues that arise while counselling women and children.

Procedure:

Read through the following scenario:

> Mrs. Lal comes for counselling and mentions that her seven-year old son, Ramesh has been difficult lately; in particular, he will not stay in school but wanders back home. She and Ramesh now live on their own. Mrs Lal is a single parent who separated from her husband two years ago after he told her he was HIV positive, the result of an affair with another man. She was then tested and found to be HIV positive. She has recently been diagnosed as having AIDS Related Complex. Ramesh has been told nothing about his parents' HIV status.

Conduct a role play the counselling session with 3 volunteers between Mrs. Lal and the counsellor using the third person as an observer. Allow 15 minutes for the role play, 10 minutes for the client to provide feedback to the counsellor, 10 minutes for the counsellor to give feedback to the client and 10 minutes for the observer's feedback. Feed back should focus on the possible feelings given below. Next focus the general group discussion on how Mrs. Lal can help her child through this problem, as well as plan for future possibilities for the child. Remember to put the volunteers through a de-role after the role play.

Points for discussion after role play:

Mother's anger as a result of:

1. Husband's unfaithfulness
2. HIV infection through husband
3. Unfairness of life
4. Ramesh misbehaving

Mother worries that:

1. The neighbours might find out she has HIV
2. Ramesh is going to get into trouble with school

Mother's fear of:

1. Her death
2. Her illness, which cannot be hidden from Ramesh
3. What will happen to Ramesh if she dies
4. Ramesh becoming HIV infected
5. Ramesh growing up to be like his father.

Ramesh's anger as a result of:

1. Father being away
2. Something being wrong with his mother and him not knowing about it.

Ramesh's fears:

1. Mother may die
2. What might happen to him

ACTIVITY 4: Role Play

Time: 45 mins.

Objective:

The purpose of this activity is to identify the range of special issues that arise out of situations related to children.

 # 1 Satinder, 26, and Meena 20 are a couple who live in a slum area in Bombay. They bring their 2 year old daughter to the hospital for an HIV test on the request of the doctor. Their daughter Manisha is HIV positive. Thereafter the couple finds out that they both are HIV positive. Satinder used to visit CSWs before his marriage. Also, Meena is 2 months pregnant.

 # 2 Lakshmi, 6, was born with a blood disorder. Subbu,28 and Janaki, 24 are her parents. Lakshmi is thalassemic and needs regular blood transfusions. During one of the transfusions she has contracted HIV virus.

 # 3 Mrs. Roberts, 41, a school teacher has found that Viren, 10, from her V standard class was declared HIV positive after a surgery where he received blood.

Procedure:

Participants can break into three small groups. Each group discusses the scenarios, considering the discussion points. After 30 minutes, they come to the bigger group where each group shares their scenario and findings. Allow 7-10 minutes for group for presentation. The trainer sums up the issues identified by the groups.

Points of Discussion:

- What are some of the special groups that exist in these situations?
- What are the special issues in relation to the special group in each situations?
- What would the fears of individuals in these scenarios be?
- What are some counselling issues that would arise?

ACTIVITY 5: Self Awareness Questionnaire

Time: 50 mins.

Objective:

This activity is designed to allow all participants to explore some of their own attitudes and become aware of their level of comfort towards certain groups that are at risk of getting infected with HIV.

Procedure:

Introduce this activity by telling the participants that this activity is designed to have them think about something in a new way. Distribute the "Self Awareness Questionnaire" **(Worksheet 1)** to all the participants. Inform them that they should not write their names on the sheet (allow 20 mins). After the questionnaires have been returned, reshuffle them and give one to each participant. Trainer goes through each question. The trainees asks for reponses from 4 participants for each question & as a result he gets 4 different responses for each question. **Remind the participants that there are no right or wrong answers.**

The trainer then discusses with the participants how their responses to the statements on the "Self Awareness Questionnaire" relate to counselling and education. Some people may resist stating opinions, as they fear their opinions may be unpopular. The trainer may have to work to get people talking initially. There may also be people stating their opinions and then trying to force those opinions on others.

This is an activity where people may experience discomfort. Remember, the discomfort that people may experience is not harmful to them or to the process. If someone is upset with the exercise, acknowledge their feelings and then continue. Relax and have some fun with this exercise.

The facilitator should discuss whether the trainees learnt something new about themselves by filling the questionaire. If so, what did they learn?

ACTIVITY 6: Review Questions

Time: 20 minutes

Allow 10 minutes to the trainees to fill **Worksheet 2.** Trainer to discuss the likely answers with the trainees.

WORKSHEET 1

Self Awareness Questionnaire

Consider each sentence as carefully as you can, then place the number indicating your feeling next to each one.

SECTION 1

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
1	2	3	4	5

1. I would feel comfortable working with a gay man.
2. I would enjoy attending social functions where lesbians and gay men are present.
3. If a member of my gender made a sexual advance towards me I would feel angry.
4. I would feel uncomfortable if I learned that my boss was homosexual.
5. I would feel nervous being in a group of homosexual people.
6. If I saw two men holding hands in public, I would feel disgusted.
7. I would feel comfortable if I learned my daughter's teacher was lesbian.
8. It would disturb me to find out that my doctor was homosexual.

SECTION 2

Answer the following questions:

1. Do you know someone who is a commercial sex worker? What do you think of her?

_____
_____
_____

2. If your brother/son came up to you and said that he was in love with a man? How would you react?

_____
_____
_____

3. Did any of your friends earn money or get expensive gifts by being call girls? What did you thik of them

_____
_____
_____

4. Do you have any friends who had sex before marriage? How do you feel about them?

5. Have you done anything that you feel guilty or ashamed about? Did you ever talk about it with someone? If so who and at what age? If you had counsellor service available, what could that person have said or done to make you feel better?

6. Name 2 groups of clients you would have moral and ethical dilemmas in working with?

WORKSHEET 2

Review Questions

1. Why is it necessary to discuss about substance abuse?

2. What are the additional factors to be considered in HIV and drug abuse?

3. What are some of the issues related to pregnancy which a counsellor should discuss with a woman who believes that she has been at risk?

4. What would a counsellor need to say to a woman who believes that an IUD (for e.g. Copper T)will protect her from HIVinfection?

5. What are some of the major counselling issues for parents of HIV infected children?

6. What are some of the major counselling issues for infected children?

7. What are some of the major counselling issues for infected individuals involved in non-heterosexual relationships.

MODULE 6
STAFF SUPPORT, NETWORKING AND DOCUMENTATION

EXPECTED OUTCOME

Trainees will become aware of the importance of staff support, networking and documentation. They will be sensitised to the importance, the skills and the need for staff support and networking and its strategies. They will become aware of the need and the different methods of documentation.

MODULE AT A GLANCE
TOTAL TIME 2 HRS 35 MINS

CONTENT SECTION

STAFF SUPPORT
NETWORK
DOCUMENTATION

ACTIVITY SECTION

BRAINSTORMING	:	45 mins
GROUP WORK	:	1 hour
GROUP DISCUSSION	:	30 mins
REVIEW QUESTIONS	:	20 mins

OVERVIEW

All health workers may be called on to examine, treat, perform some procedure on or counsel an HIV-infected person or AIDS patient. Even well trained health workers may then be affected by irrational fears of becoming infected or feel frustrated and depressed because of the invariably fatal outcome of the disease. Health workers therefore need education and counselling. They often succumb to burn-out and that is why staff support is very important. Staff support enhances efficiency and productivity, reduces effects of work stress and protects from work hazards. Health workers should be encouraged to formulate groups not only inside hospitals but also between organisations to form a support network. Documentation is also an important aspect which helps the health worker or counsellor by recording essential facts in a systematic manner, and is a tool for professional learning.

CHALLENGES AND PROBLEMS IN HIV/AIDS COUNSELLING

"Any category of health worker may be called to examine, treat, perform some procedure on, or counsel an HIV infected person or AIDS patient" (WHO Counselling Manual). Besides these tasks, the health worker may be called upon to counsel, or otherwise support the infected and/or their families or intimate friends. These tasks bring with them certain problems with them that the health workers engaged in HIV infection related work have to face. These problems are:

- Many a times the health workers bring a certain set of values, biases and prejudices with them. These biases may prove a hindrance in the acceptance of the clients as persons, and can thus affect the service. For example, the worker may not be able to accept a client whose life-style or circumstances may lead to his/her being infected.

- Health workers may be overwhelmed by the social and emotional issues confronted by them during their work. Breaking the news, talking about death, facing the grief of family members and discussion sensitive topics like sexual orientation can produce emotional stress which needs to be recognised and handled. Such emotional stress, if persistent, can have effects like reduced productivity and problems in team work.

- The burden of caring for patients who have a virtually hopeless prognosis can affect the staff causing frustration, depression and a sense of despair.

- Health care workers may be torn by conflict between their professional duty to care for infected patients, and their fear for their own safety. Their anxiety about infection may cause them to exaggerate precautions to the extent of withholding or seriously reducing the quality of care or of the service they are expected to give.

- Lack of understanding or support from other levels of staff in the health care facility or lack of cooperation or appreciation.

All these circumstances lead to a phenomenon called **burn out.** It refers to a progressive loss of idealism, energy, and purpose and is experienced by people in the helping professions as a result of the conditions of their work. Being faced with young, seriously ill, dying people, inadequate facilities, understaffed health care institutions, insufficient training and client overload are some such conditions which may foster burn-out and subsequent alienation towards work. Over time the burn-out effect may be expressed in emotional withdrawal, hostility towards persons with AIDS and the staff-members, depression and cynicism. Physical symptoms of burnout include ulcers, headaches, backaches, and other such problems.

In organisational terms, burn-out is expressed by:

a) Absenteeism
   - repeated short term absences.

b) Accident prone behaviour
   - prolonged absences due to illness or injury
   - repeated minor accidents
   - more than one major accident

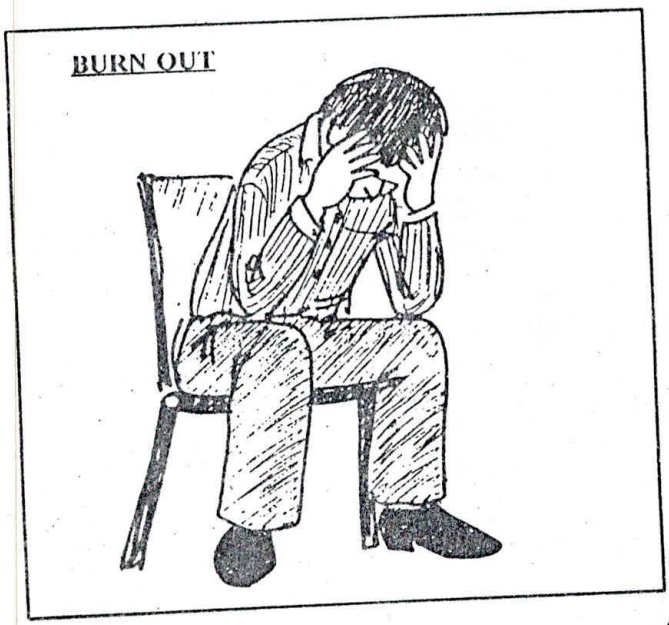
c) Unrest
   - interpersonal friction
   - occupational stress

d) Transference and Counter Transference
   - expectations of clients' from counsellor increase
   - counsellors becomes emotionally involved with their clients

Once the counsellor gets emotionally involved with his/her client he/she finds himself/ herself unable to work objectively with their client.

The cost in terms of reduced productivity, reduced quality of care, and excessive use of benefits is high for the health care system. When employees leave their jobs out of frustration, there is loss of trained and experienced personnel.

The health care staff, therefore, need support programs for avoiding 'burnout' situation, and for improving their involvement in their work.



Staff Support

Staff support is expressed through programmes which:

(i) recognise the vulnerability of the staff and
(ii) enhance efficiency/productivity,
(iii) reduce effects of work stress,
(iv) protect from work hazards.

In organisational terms, burn-out is expressed by:

Essential steps to provide staff support are listed below:

a) Enhancement programmes

These include arrangement for training and other staff development programmes. Some of these are:

- Formal discussion groups like an inhouse staff clinical society where problems/ issues regarding work can be discussed and dealt with.
- Provision of library for the use of staff.
- Nomination of staff to conferences, workshops, etc.
- Refresher courses.

Some informal programmes can be instituted by the staff themselves. Examples of these are Journal club, Study Group. etc.

b) Stress Management Programmes

The staff can be encouraged to keep mentally and physically fit by providing programmes to help recognise and manage stress. However, difficulties like lack of space, shift duties, lack of funds, and difficulty in convincing the staff themselves, hamper such programmes in hospital settings.

There are several approaches to reducing stress at work:

- Modification of work practices or organisational characteristics to diminish the causes of stress.
- Assistance in development of personal coping mechanisms.

c) Organisational approaches and supervision

- Regular staff meetings to allow venting of feelings, provide support to encourage innovation.
- Flexibility in job arrangements.
- Adequate work load/staffing.
- Early recognition of complaints and early redressal (specially interpersonal problems).
- Fostering team-work.
- Encouraging staff participation in planning and -not only in implementation.
- Frequent inservice education sessions and other opportunities to improve skills and confidence.
- Monthly staff meetings where each counsellor gets to present a case study and there is a group discussion on the issues presented in the case.

STAFF MEETINGS

Supervision mainly consists of holding ongoing weekly supervision meetings to discuss issues and feelings being aroused within the workers. Usually, a senior staff worker serves as the supervisor for the team and mentors/guides the work and professional growth of the staff members. Supervision is more effective when done on a one to one basis (supervisor with one staf member at a time).

This process should include an update on the progress made in each case by the counsellor as well as his/her own feelings aroused by the process and the intended plan of action for the next few sessions with the clients. It's important for the supervisor to watch out for issues that may be personally intense or difficult for the counsellor, expecially where there is a clouding of judgement and ambiguity in the worker. The supervisor needs to point these out to the concerned in a supportive, nonjudgemental and direct manner. Suggestions on how to take care of oneself and enhance one's professional growth also form an essential part of effective supervision.

d) Counselling

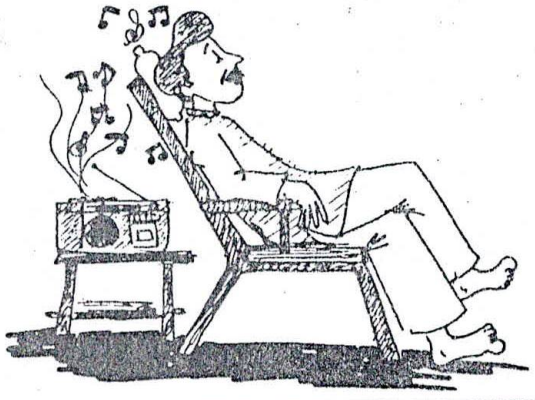
Sometimes just being able to talk about the stresses - frustrations fear, guilt, anger, inadequacy with others who share the same job stresses is therapeutic. Encouraging formal and informal counselling and peer-support groups would help. These are not therapy groups, but have characteristics of self-help groups. The discussions in these groups may lead to constructive group strategies for coping as workers are encouraged to share not only the problems but even the successes, for e.g. techniques developed and tried out by them.

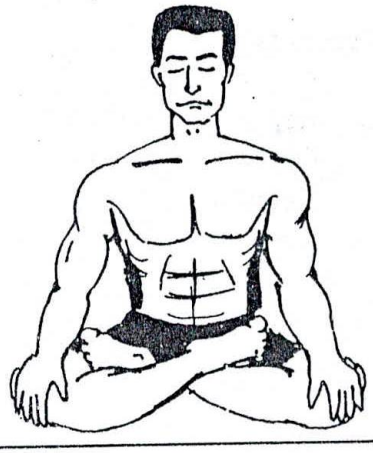
While group sessions may help the majority, some workers may need individual counselling. There may also be a need of psychiatric/psychotherapeutic consultation.

e) Personal Coping Mechanisms

Staff can be helped to develop better coping mechanisms so as to avoid or reduce job-stress. Training sessions should include identification of causes and symptoms of stress/burn out and help them develop coping plans. Some of the strategies could be lifestyle education, exercise, biofeedback, progressive muscle relaxation, cognitive restructuring meditation, yoga and others.

SOME PERSONAL COPING MECHANISMS





The staff could also be encouraged to form their own groups. Expert help can be given by inviting visiting faculty. There are of several studies showing that simple meditation like relaxation techniques can have a dramatic effect. In a study at a large Cincinnati Hospital, nurses received training in bio-feedback, muscle relaxation in daily, one hour sessions, over a two week period. After three months, both the biofeedback and muscle-relaxation groups showed significant improvement in the ability to cope with stress, increased job satisfaction and energy levels at work, and fewer sleep disturbances.

Staff who turn to substance abuse as a maladaptive coping mechanism also need help. Narcotic, alcohol and tobacco addiction has been noted in various categories of health staff. Steps to be taken by the organisation may begin with pre-placement screening, different kinds of secondary prevention programmes (Employee Assistance Programmes) and rehabilitation.

Protection from work hazards

Health care workers, particularly those who have frequent contact with blood, are at a risk of acquiring blood-borne diseases, including HIV. This emphasises the need to develop a practical approach towards the prevention of these infections in the health care setting.

As blood borne diseases are frequently carried by asymptomatic patients, it is not always practical or feasible to expect to know the blood disease status of each patient. Therefore, universal precautions are absolutely essential.

Occupationally, HIV infection among health care workers due to work-related causes is a rare event. However, in circumstances when testing is indicated, the worker must receive the benefit of pretest and post-test counselling service. It must be seen that:

- Testing is voluntary
- Informed consent is obtained prior to testing
- Confidentiality of tests is assured
- Laboratory testing is done if needed
- Confirmatory testing is done if needed
- Worker is protected against discrimination

Education is, at present, the most effective defense against the spread of HIV infection. The employees' health service must assume a leadership role in educating patients and staff about ways to prevent the spread of HIV.

NETWORKING

Health care workers should be encouraged to formulate groups not only inside hospitals but across other organisations to form a support network. There could be through formal as well as informal channels.

Frequent contact between agencies, non-governmental organisations (NGOs), governmental organisations etc., working in the HIV/AIDS field is needed so that health workers are aware of available services and they make the general public aware of available services. Health workers should also meet regularly so as to discuss difficult and debatable issues.

Connections need to be established with service organisations in the vicinity of the counselling center/hospital for referrals. They could be at state, national and international level for example, Family Planning Association, Indian or International Planned Parenthood Association and such others. In situation where the client has to be referred to other groups for specific support or help, networking is of great assistance.

DOCUMENTATION AND MONITORING

Documentation is not only an important tool of learning, but it helps the organisation/ counselling service by recording essential facts about clients and about the process of counselling. It also helps to keep information in a systematic manner.

Types of records

- Reports/Assessments
- Graphic presentations/Genograms
- Registers
- Case notes

Records should be maintained regularly. The clients' case record should include

(1) an assessment done at the beginning stage of treatment,
(2) regular case notes maintained for each session with the client,
(3) any other interactions with the client on phone should also be noted, and
(4) in case the counsellor involves other professionals/resource persons, the records of these interactions should also be kept.

What to record

The organisation, format and content of case or client records will vary from agency to agency. However, most records need to contain two types of information :

(1) the raw data and
(2) the worker's (counsellor's) thoughts about the meaning of that data.

The raw data is the basic facts about the clients and his or her situation. An assessment summarising the worker's impressions and hypothesis gives added meaning to the data and should also be included.

A good report is characterised by

1. **Brevity:** The report should say no more than needs to be said.
2. **Simplicity:** Select the least complicated words and phrases. Avoid jargon, like psychiatric labels, describe and give examples of the behaviours you want the reader to know about.
3. **Usefulness:** Keep the report's purpose in mind. Do not include information merely because it is sensational or interesting. Ask yourself why you want to write this report and what those who read it need to know.
4. **Organisation:** Plan and outline the information you need to include. Use headings to break information into topical parts.

The following are the headings which are often used in social history assessments:

- Identification data (name, age, sex).
- Reason for coming to the clinic/center
- Statement of problem
- Family constellation, significant others and interpersonal relationships.
- Physical functioning, health practices and health problems.
- Sexual practices, sexual health and problems.
- Intellectual functioning and educational backgrounds.
- Emotional functioning and problem-solving capacity
- Employment and economic situation
- Housing
- Nutrition

5. **Confidentiality:** It is very important to respect the client's right to confidentiality. Client infromation which needs to be protected should be included after careful thought. Access to the record should be restricted to staff.

6. **Objectivity:** Select words that express your observations and thoughts in an accurate and non-judgmental manner. Avoid value-laden phrases and words which give connotative meanings. Some examples are:
   - Client has some sexual practices like homosexuality.
   - The client claims to have taken drugs.
   - The client is a prostitute.

   Though you will need to give your impressions and opinions, examine them carefully to see whether they contain subjective judgments. It would be best to give this under a separate heading "Health worker's or Counsellor's opinion, observation and assessment".
7. **Relevance:** The information included in the record should have a clear connection with the client's problems to avoid cluttering.
8. **Focus on client strengths:** Emphasis can be given on what the client/family can do, not on what they cannot do. Successful intervention is based on client strength.

Monitoring focuses on **implementation** and ongoing activities rather than outcomes or the impact of a programme. The purpose of monitoring is to anticipate, prevent and safeguard problems in implementation thereby preserving or protecting the quality of any programme. Monitoring begins with the development of a systematic awareness of the progress of activities,

This can be done by carefully developing and selecting some key indicators which would give information and insight about how an organisation or programme is progressing towards its goals. Thus timely and regular reporting of information about these selected indicators helps the programme managers identify any bottlenecks or barriers which may be affecting the programme. The next step would be to collectively with counsellors, nurses, chief medical officers, project managers/directors and brainstorm on a possible solution or constructive steps to eliminate these barriers. Monitoring should be more "proactive" rather than "reactive", evaluative to the problems and maintain a certain level of performance as well as move the project or activities forward.

Finally, monitoring is an ongoing activity which guides and helps shape the programme rather than being a final outcome/evaluation of the impact of all the activities that have comprised the programme.

Suggested Readings :

AMA Management Briefing (1985) : AIDS : The Workplace issues

Edelwich J. with Brodsky A(1980): Burn out New York : Human Sciences Press

Lyons J.V. & Moritev K. Y. (editors): Regional counsullation Partnerships for AIDS prevention. UNDP publication.

Mckay M. & Fanning. P (1985): Meditation and Inspiration. Celestial Arts (publishers)

ACTIVITY 1 - Brainstorming - The Challenges Faced in HIV/AIDS Counselling

Time: 45 mins

Materials: Chart paper and markers

Objective: The purpose of this activity is to discuss the challenges faced in HIV/AIDS counselling.

Procedure:

As a large group, brainstorm responses to the following question: **Which major challenges or difficulties do you face while doing HIV/AIDS counselling?**

Review the list which comes out of this exercise, and tell the group which major challenges will be discussed in the lecture session. If needed, discuss some of the points raised by the group but not covered in the lecture.

Points of discussion

Recommendations for the better counselling might include:

- Acknowledge that HIV/AIDS counselling is exhausting work.
- Acknowledge that we all have limitations as counsellors because we are only human.
- Become aware of our prejudices, biases and assumptions so that they do not interfere with the counselling process.
- Find support from colleagues who are also working as HIV/AIDS counsellors.
- Plan ahead and make alternate arrangements whenever possible.
- Ask a colleague to conduct a counselling session for you if necessary.
- Postpone the counselling session when appropriate.
- Develop skills in organising your schedule better.
- Learn to accept that you cannot change the client's life or behaviour for him/her.
- Feel good about your work as counsellors even when limitations prevent you from doing all that you would like to do for your clients.
- Learn additional information or skills necessary to improve your abilities as a counsellor.
- Be aware of your personal limits.
- Learn how to treat a client with acceptance and respect even if you do not like him/her or agree with his/her life choices.

- Consult with other counsellors to get feedback about your reactions and to get support. Ask them to help you understand your reactions better.
- Refer the client to another counsellor if it is necessary and if one is available.
- Find creative ways to support each other. For example, form counsellor support groups in your area.

ACTIVITY 2: Group Work: Planning for our own Limitations

Time: 1 hour

Materials: Large paper, markers, tape, paper, pencils

Objective:

The purpose of this activity is to discuss the limitations counsellors experience on the job and ways to cope with them.

Procedure:

It is important to acknowledge that HIV/AIDS counselling is very demanding and that as counsellors, we all have personal limitations. Since our first obligation is to our clients, we must identify our limitations and find ways to help ourselves and each other cope with these limitations so that they do not interfere with counselling. In this activity we will be sharing our experiences and ideas about coping with personal limitations. Ask participants to think of a real or imagined counselling situation when they were aware of their limitations as counsellors or when they felt their personal lives affected their counselling (i.e. issues of counter transference). Ask each person to write answers to the following questions:

- Describe the situation
- In what ways did you feel limited?
- What did you do or say?
- How did you feel about yourself and your counselling skills?
- Could you have handled the situation any better? What might you have done differently?

Divide the group into small groups of 4 to 5 people. Ask each person to share what he/she has written with his/her small group. Ask each group to discuss the common ideas and situations in the stories of the group members. Ask each group to complete the following task: Based on their discussion, each group is to write on a large sheet of paper "10 ways to cope with personal limitations." When each group is finished, their sheet of paper should be taped on the wall. Invite participants to walk around the room and read each group's list. Return to the large group and discuss the ideas. Make one large list of ideas for coping with personal limitations, eliminating duplicate answers. Discuss how this list can be useful. Consider ways to make it available to other counsellors.

ACTIVITY 3: Group Discussion : Coping with the Stress of HIV/AIDS Counselling

Time: 30 mins

Materials: Large paper, markers, tape

Objective:

The purpose of this discussion is to identify effective ways to cope with the personal and work-related stress of HIV/AIDS counselling.

Most trainers have, or will, experience stress as HIV/AIDS counsellors. They can support each other by sharing the ways they have found to cope with this stress.

Procedure:

Ask participants to share one way they deal with the stress of working as an HIV/AIDS counsellor. As each person states his/her idea, record it on a large sheet of paper at the front of the room. Review the following the points of discussion.

Points of Discussion

Ways to cope with stress might include:

- recreation
- discussing certain problems with senior counsellors or fellow counsellors
- finding a quiet place to think
- meditation
- spending time alone
- relaxing
- joking, using humour
- prayer
- group meetings with other counsellors

ACTIVITY 4 : Review Questions

Time: 20 mins

Allow 10 minutes for trainees to complete **Worksheet 1**. Trainer should discuss the most appropriate answers (Allow 10 mins).

WORK SHEET 1

Review Questions

1. What is "burn-out"?

2. What emotional reactions are cause for concern in health workers who are suffering burn-out?

3. What types of interventions or activities might a programme manager undertake in order to prevent or deal with burnout in the workplace?

APPENDIX 1
PRACTICAL INFORMATION FOR PEOPLE WITH HIV INFECTION OR DISEASE

Counselling for both support and prevention is needed in the post-test or post-diagnosis phase. In addition, to acknowledging and working with the psychological issues that appear at this time, in clients who are HIV-infected, the counsellor should emphasise information that provides the framework for living with HIV. Similarly, as part of the process, the following points should be covered repeatedly in all counselling sessions, for both HIV-positive and HIV-negative people:

1. HIV infection is not the same as AIDS. People with AIDS have HIV infection, but only a proportion of those with HIV have AIDS.

2. Sexual intercourse, whether heterosexual or homosexual, is the major route of transmission of HIV. The virus can be transmitted by any penetrative sexual act in which HIV-infected semen, vaginal/cervical secretions, or blood is exchanged. HIV infection can be prevented. During each act of sexual intercourse, men should always use a condom. Women should make sure that their partners use a new condom for each act of sexual intercourse. Instructions of the use of condoms are given in section 2, and guidelines for sexual practices are presented in section 3.

3. Condoms, when carefully and consistently used, provide effective protection against HIV transmission. Latex condoms lubricated with silicone or water-based lubricant are recommended. When additional lubrication is desired to reduce the risk of condom breakage, only water-based, (not oil-based) lubricants should be used. Animal membrane (e.g., lambskin) condoms are not believed to be as effective as latex condoms as a barrier against HIV and are therefore not recommended.

4. Non-barrier contraceptives such as intrauterine devices (IUDs) have no protective effect against HIV transmission. It is not clear whether oral and injectable contraceptives affect the risk of HIV transmission. Coordination between AIDS control and family planning services is clearly essential.

5. Certain health conditions, especially other sexually transmitted diseases may accelerate the progression of HIV infection to AIDS. Guidelines for avoiding sexually transmitted diseases should be followed by people with as well as those without HIV infection. Section 3 contains excerpts from the WHO publication, Prevention of Sexual Transmission of Human Immunodeficiency Virus (HIV). This type of information must be clearly explained to the client and, with the explicit agreement of the client, to his or her sex partners, if that person is known and accessible.

6. It is not yet clear whether pregnancy accelerates the progression of HIV infection to AIDS. The uncertainties about this must be carefully explained to infected women of childbearing age. The risk of transmission to the foetus is 20-45%. If a woman has AIDS she is more likely to have problems with the pregnancy. If HIV-infected women want to avoid pregnancy, advice about contraceptives should be given to them and their sex partners. Access to safe and reliable contraceptive methods must be ensured.

7. With regard to immunization, studies have demonstrated that the use of the following vaccines is safe in children suspected of being infected with HIV-1; BCG, DPT, OPV, IPV, measles vaccine and tetanus toxoid (all the standard vaccines recommended for children). However, BCG should not be used if a child has symptoms of HIV-related disease. The safety of other live vaccines, such as yellow fever vaccine, 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 (EPI). 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.

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

9. If blood from a person infected with HIV is spilt in the home or workplace, it should be cleaned up with an absorbent material (such as cloth, rag, paper towel, or sawdust), while avoiding direct skin contact with it. The blood-soaked absorbent material should then be disposed off 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 spills. If gloves are not available, another barrier such as a plastic bag, a large wad of paper, towels or cotton should be used to protect against direct skin contact. 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. Household (rubber) gloves should be worn, if available, and the clothes or pieces of cloth 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 off immediately after use. Bandages and other dressing soiled with HIV-infected blood should be similarly disposed off. If they cannot be placed in tied plastic bags, they should be burnt or buried. If cloth or material is used for menstrual blood, these should be wrapped in plastic or paper until laundered.

10. People with HIV infection should not share syringes, needles, or other skin-piercing instruments, as this adds the risk of transmission of HIV and other pathogens to the existing risk of such practices. 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.

11. People with HIV infection should not share tooth brushes, blades, razors or other instruments that could become contaminated with blood (even though the risk of HIV transmission from these devices is extremely low).

12. 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 as to 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. At least one drug, zidovudine (also known as AZT), has proved effective in extending survival time and relieving symptoms in some patients. 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.

13. 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.

    Counselling should also emphasize socially constructive behaviours and activities that do not involve a risk of HIV transmission. Casual social contact, sharing crockery and cutlery, being in the same room, sharing swimming pools and lavatories do not pose a risk to anyone and help to maintain a feeling of social cohesion.

    Drug injectors who are unable to stop using drugs should be told where they can obtain sterile needles and syringes (if this is possible) or how to disinfect, injecting equipment using bleach. Some countries or cities have needle and syringe exchange facilities. 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 prostitutes and the client. Special care is needed in counselling those thought to be doing this, by regularly providing condoms, and by encouraging them to insist on their use.

    Sex partners of drug injectors may be at risk of acquiring HIV infection and other diseases if sexual intercourse occurs without the use of condoms. Counselling and information should always be provided for the sex partners of drug injectors on how to avoid possible HIV infection by the adoption of safer sexual practices.

14. Positive health behaviours need to be actively encouraged. The specific behaviours to be encouraged will vary from one social groups to another. The counsellor will need to be specific to meet the needs of individuals and special situations. It is important to stress to HIV-infected people how they can live with AIDS. In the following section are some general guidelines for living with AIDS.

Section 1 : Living Positively with AIDS

A person with AIDS should try to keep the body strong. This means they should

- ❑ Eat a balanced diet whenever possible including food which is rich in proteins, vitamins and carbohydrates. Nutritional deficiencies may adversely influence immune system.
- ❑ Stay as active as possible 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 oneself 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.
- ❑ Seek medical attention for health problems and follow advise for care including counselling and social services. This includes preventive services such as immunization for children and infants with HIV/AIDS.
- ❑ Reduce stress by identifying potential and actual stress factors.

They should **avoid**:

- ❑ alcohol and cigarettes.
- ❑ other infections-including further doses of HIV.
- ❑ pregnancy because it lowers the body's immunity in some cases hastens the onset of AIDS in HIV positive women.
- ❑ Using unprescribed drugs.
- ❑ Isolating themselves.

Section 2 : Instructions for condom users

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

- ❑ Use a new condom each 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 end of the condom. Do not pull the condom tightly against the tip of the penis; leave the small empty space (1 to 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 and use 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 off used condoms by flushing, burying, burning;
- ❑ if a lubricant is desired, use a water-based one-petroleum jelly may damage condoms;
- ❑ do not use saliva as a lubricant - it is ineffective and may cause the condom to break;
- ❑ store condoms away from excessive heat, light, and moisture - these cause them to deteriorate and perhaps break;
- ❑ condoms that are sticky or brittle or otherwise damaged should not be used.

The counsellor must make sure that condom users understand and follow these instructions. If they prove difficult to follow, the counsellor must explain them in a simple language and with the aid of graphic material. The counsellor should consider adapting the culturally appropriate graphic material already used by the local family planning services.

Section 3 : Guidelines on preventions of sexual transmission of HIV

The following general guidelines are aimed at individuals or groups. They may need to be adapted to different local situations.

1. Recommendations to all persons to prevent sexual transmission of HIV
   (a) Be aware that, if you have a mutually faithful relationship with your sexual partners, if you are both HIV seronegative, and if neither of you is exposed to contaminated blood e.g., by intravenous drugs or sharing needles, you are not at any risk of a sexually transmitted HIV infection.
   (b) If you intend to have sexual intercourse and are not in a mutually faithful sexual relationship, be aware that your chance of acquiring HIV infection is influenced by the following three, main factors.

1.The choice of your sexual partner(s)

The risk of infection is directly related to the likelihood that your partner may be infected; for both heterosexual and homosexual partners. However, there is no way to know whether someone is infected by looking at him/ her. Therefore, the use of condoms is the only way to avoid exposing oneself to the risk of infection.

2.The number of sexual partners

The greater the number of partners with whom you have sexual intercourse, the greater the likelihood that you will encounter a partner with HIV infection. Therefore reduce the number of sexual partners to the greatest extent possible.

3.The type of sexual behaviour practiced

Abstinence is the best way of preventing sexual transmission of HIV infection. 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 becoming infected with HIV or transmitting HIV to a sexual partner.

Restriction of sexual contact to activities that do not involve the sharing of semen, vaginal and cervical secretions, of blood (e.g., hugging, caressing) will eliminate the risk of acquiring HIV infection. Other "safer sex" practices include masturbation, massage, kissing and hugging. Oral sex should be avoided if there are sores present in the mouth or on the genitals. These precautions are also advised for men having sex with men, or women having sex with women.

II. Recommendations to HIV-infected persons

(a) Inform potential sexual partners of your HIV infection and decide either to avoid sexual intercourse, or rigorously restrict sexual contact to activities (e.g., hugging, caressing) that do not involve sharing of semen, vaginal and cervical secretions, or blood. Discuss the precautions that need to be taken to minimize the risk of HIV transmission from sexual activity (e.g., the use of condom).

(b) If you both decide to engage in penetrative sexual intercourse, learn how to use condoms correctly as consistent, correct use will reduce the risk of HIV transmission.

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

(d) Avoid pregnancy. HIV-infected women who are pregnant should know about the health risk to their unborn children and the potential health hazard to themselves, and should be provided with counselling services. HIV-infected men should discuss the hazard of pregnancy with their partners.

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

(f) Mothers should continue to breastfeed.

(g) 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 evaluation (including, if available, serological testing). If you are unable or unwilling to notify former and current sexual partners personally, request health workers or public health agencies to notify or help with notifying such partners.

(h) Do not share syringes, needles or other skin piercing instruments.

III. Recommendations to sexual partners of HIV-infected persons

(a) Contact a health-care provider for counselling and evaluation (including, if available, serological testing). If the HIV serological test is negative and you are clinically healthy, and if the last unprotected sexual contact or needle-sharing exposure with 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, or if you continue to have sexual intercourse with your infected partner, repeat tests will be necessary to determine whether infection has occurred. If you were negative on initial serological testing, see the recommendations below.

(b) Be aware that avoiding sexual intercourse with an HIV-infected person or rigorously restricting sexual contact to activities that do not involve sharing of semen, vaginal and cervical secretions, or blood (e.g., hugging, caressing) is the only way of eliminating the risk of acquiring HIV infection from the person. If this is not acceptable, the use of condom is an alternative, but it is not without risk. Although the precise effectiveness of condoms in preventing HIV infection is unknown their correct and consistent use will significantly reduce the risk of transmission.

(c) 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.

(d) If you are pregnant, find out and seek counselling about HIV-antibody testing. If you are tested and found to be seropositive, find out and seek counselling about the significant health risk to your unborn child and the potential risk to yourself.

(e) Dot not donate blood, plasma, semen, breast milk, body organs, or other tissues.

(f) Offer HIV testing information and counselling to people at increased risk of infection.

IV. Recommendations to health-care providers

Doctors, nurses and other staff who are handling HIV infected patients, their blood products or their lab specimens are also likely to be worried about their risk of infection. The counsellor has to be aware of such risks. The risks in reality are very low and to date there are only a few people known to be infected, from the hospital through looking after HIV/AIDS patients. However, there is a potential risk and care must be taken whenever blood and such samples are handled, so that it does not come into contact with broken skin. WHO estimates that the risk of infection through a needle stick injury (needle having been used on an HIV infected person) is lower than 1 in 200. The counsellor who is involved in counselling health care providers can get more details from the NACO and WHO Manuals for Health Care Workers.

APPENDIX 2
UNIVERSAL HEALTH PRECAUTIONS

THE PRINCIPLE OF UNIVERSAL INFECTION CONTROL:

Health care workers must strictly follow infection control precautions at all times and for **all patients** irrespective of HIV status. At the outset, the following points are very important for all personnel in healthcare settings :

- ❑ The risk of HIV transmission from patient to health-care worker (or vice-versa). is minimal i.e. 0.01% (there being no intimate contact involved).
- ❑ However, the lethal nature of HIV makes precaution essential.
- ❑ Besides, the nature of precautions to be taken for HIV prevention are extremely simple and basic. They also help to minimize the risk of many other infections.

> Transmission of HIV occurs in a pattern similar to that of Hepatitis B - the precautions appropriate for Hepatitis B are therefore simillar to those against HIV

PRECAUTIONS TO BE TAKEN FOR INFECTION CONTROL

Given below are the precautions to be observed while dealing with all infectious cases, including HIV.

A. When you are likely to come into contact with BLOOD or any other BODY-FLUID:

- ❑ Always use barrier protection
- ❑ Always wash your hands thoroughly after taking off the gloves- plain soap and water will do
- ❑ Be very careful while handling specimens of body-fluids. They must be kept in good containers, sealed and put into waterproof bags and labelled 'BIO-HAZARDOUS'.
- ❑ If any body-fluid is spilled either by the patient or by you,

  (a) Use fresh chlorine over it,
  (b) Swab with cotton,
  (c) Pour chemical disinfectant,
  (d) Wipe,using disposable gloves
  (e) Dispose cotton, swab, gloves etc. in incinerator.

BARRIERS TO BE USED WHILE HANDLING BLOOD AND BODY FLUIDS

GLOVES protect you when you have unnoticed cuts and wounds in your hands	GOWNS/APRONS protect you if your clothes get soiled by the patients body-fluids	FACE SHIELDS/MASKS protect you when body fluids get sprayed or splashed on to your face

* **Avoid direct contact if you know you have a cut/wound.**

B. Given below are the precautions that need to be taken while using NEEDLES and INJECTING MATERIAL (syringes):

- ❑ It is best to use disposable equipment, eg. needles, syringes, etc. However, if this is not feasible, decontaminate all equipment
- ❑ To decontaminate all reusable equipment, use disinfectants or sterilization (See section on sterilisation and disinfection for details)
- ❑ In case of a needle-stick injury,
  - (a) Throw away torn-glove
  - (b) Wash wound until blood disappears
  - (c) get blood-tests done at regular intervals for next one year
- ❑ Never reuse disposable equipment - put them into incinerator after use.
- ❑ Always dispose disposable equipment in puncture-resistant containers.

PRECAUTIONS TO BE USED WHILE USING NEEDLES AND SYRINGES.

Do NOT REINSERT needles	DO NOT BEND/ BREAK needles with your hands	DO NOT REMOVE needles from disposable syringes

C. If you are handling a patient's LINEN/ DISPOSABLE ITEMS :

- ❑ Treat all soiled linen as 'infectious' and keep separate
- ❑ Store and transport them, in leak-proof bags, to laundry
- ❑ Use gloves while handling

D. If you are going to perform any INVASIVE PROCEDURE :

- ❑ Maintain strict adherence to recommended infection control guidelines
- ❑ Use barrier-protection which is tailored to individual needs.

E. Isolate persons with HIV/AIDS only if....

- ❑ Patient lacks personal hygiene
- ❑ Patient suffers from communicable opportunistic infections
- ❑ Bleeding is present
- ❑ There is uncontrollable behaviour due to dementia
- ❑ Co-patients who are themselves immunosuppressed are present.

OTHERWISE, ISOLATION IS UNNECESSARY.

F. For EMERGENCY RESUSCITATION :

- ❑ Use a thin plastic sheath over the mouth before providing mouth to mouth resuscitation.

G. Masks and protective eyewear should be used..

By	When
Health workers	Dealing with all patients who might be infected or involve splashing of fluids
Patients	Suffering from communicable pulmonary infections

H. For AUTOPSY and MORTUARY Procedures :

- ❑ Presence of minimum number of attendants
- ❑ Use Barrier protection
- ❑ Decontamination of all equipment and surfaces
- ❑ Careful disposal of body fluids, faeces etc, into sanitary sewer.

I. Health workers with HIV infection must be instructed to :

- ❑ Always use barrier protection
- ❑ Avoid mouth to mouth resuscitation
- ❑ Avoid caring for immuno-suppressed patients.
- ❑ Avoid direct patient handling if suffering from lesions, cuts, open wounds etc.

THERE IS ABSOLUTELY NO REASON FOR HEALTH WORKERS OR RELATIVES, TO REFUSE CARE FOR PERSONS WITH HIV/AIDS.
(Only pregnant women with suppressed immunity may be exempt)

Counsellors may suitably adapt the above infection control guidelines for the purpose of guiding and training those caring for persons with AIDS (PWAs) at home.

DISINFECTION AND STERILIZATION PROCEDURES

- ❑ First wash equipment with COLD water and ordinarydetergent.
  DO NOT SPLASH while rinsing.
- ❑ Then use either heat or chemical disinfectants, depending on the equipment to be disinfected or sterilised.

Heat (56 ^{0} C) by using one of the following methods:
Autoclaving (Presssurized steam)
Boiling (30 mins)
Dry air-over

Chemical methods using some of the following:
Ethylene-oxide gas
Ethanol
Formalin
Dettol
Glutaraldehyde
Iodine

(Source : WHO: Self learning manual for HIV/AIDS for grass root level workers)

GLOSSARY

Acceptance : Receiving a client, unconditionally without reservation or judgement but with warmth, genuineness and positive regard.

Accessibility : Implies that counselling facilities be available easily, at a neutral location and should be conveniently approachable.

AIDS : Stands forAcquired Immune Deficiency Syndrome. Acquired - one is not born with it but gets it as a result of certain behaviours. Immune - this means protection. Deficiency - Affected body's immunity is depleted, there is not enough protection. Syndrome -A cluster of symptoms.

Antibody : A protein molecule produced by the body's immune system to interact with specific antigen that has invaded the body.

Antigen : Any substance capable of inducing the production of antibodies by the immune system.

ARC : Stands for AIDS related complex. By the time that the HIV virus has severely damaged the natural immune system the person may be suffering from diarrhoea, excessive loss of weight, skin rashes, etc. At this stage the sufferer can sometimes be more ill than the "full blown AIDS" sufferer and may be in need of a great deal of care and support. These symptoms may persist for many years.

Burn out : It is a term used to refer to a progressive loss of idealism, energy and purpose experienced by helpers as a result of the conditions of their work.

Condom : A sheath usually made of rubber that fits over the penis during sexual activity. A latex condom can reduce the risk of HIV infection The risk factor depends on the quality of the condom, state of mind of the individual using it and the sexual activity engaged.

Counselling : Involves two people, who meet to resolve a crisis, solve a problem or make decisions involving personal, intimate matters and behaviours.

Elisa : Enzyme Linked Immuno Sorbent Assay - HIV antibody test.

Empathy : Accurately sensing the clients world verbally sharing our understanding with the client.

Haemophilia : An inherited condition that affects the normal clotting of blood, thus leaving the individual at risk of severe bleeding.

Heterosexual : People attracted to members of the opposite sex.

High risk behaviours : Behaviours which make people more decisions involving personal, intimate matters and behaviours.

HIV : Stands for Human Immunodeficiency Virus. HIV is the virus that eventually lead to AIDS.

Homosexual : Person attracted to members of the same sex.

Immune System : An efficient mechanism in the body that protects against diseases.

Immunity : The power of the body to resist any effects by micro-organisms and their products.

Infected : Refers to the person who has the HIV virus within his/her body.

Infection : HIV enters the body, the blood stream and starts infecting the cells.

Macrophages : One of the components of the immune system that destroys invading antigens.

Negative Test : No antibodies against HIV found in patients blood this time.

Opportunistic Infections : Infections that are caused by organisms which usually cannot induce disease in people with normal immune systems.

Pandemic : A global epidemic.

Paraphrasing : Rephrasing of a clients' statement.

Positive Test : Patient is HIV positive i.e. his/her blood contains the antibodies produced by the presence of HIV in the person.

PWA : Stands for Person With AIDS.

Reflecting : Paraphrasing or communicating the affective component of a client's message.

Sero-conversion : Body begins producing antibodies to fight off the virus. They can detected in a blood test called ELISA.

Seropositive : Describes a person whose blood shows the presence of antibodies to the infection. Antibodies to the HIV virus generally drop within three months after being infected.

Sexual Abstinence : Not having sex with anyone.

Sexual Fidelity : Two people having sex with each other only.

STD : Stands for Sexually Transmitted Disease. Diseases that can be transmitted during sexual contact, for eg. syphilis, herpes etc.

Vaccine : Any substance that is innoculated for prevention of a particular disease.

Western Blot : HIV antibody test, used as a confirmatory test.

Window Period : 6-12 week phase between HIV infection and sero-conversion in the blood. In this period, a blood test may not reveal the presence of the antibodoes. Hence, the person may not find out if he/she is infected but he/she will be infectious.

Glossary of Training Terms

Activities : An activity is a set of specific functions carried out by the trainees together with the trainer in order to achieve the objectives.

Brainstorming : It is an activity used to open a discussion on an issue or to stimulate the group. Trainees are asked to give their ideas and opinions on a specific topic while other trainees are asked not to pass judgement on those opinions. The trainers responsibility is to list everything that is said on the blackboard. The aim is to continue exploration until all ideas have been exhausted. This activity is done for a pre-determined time.

Case Study : A case study is a story that can be analyzed, and from which learning can occur.

Group Discussion : Group discussion is a process that uses the group to disseminate information, analyze ideas or teach concepts. The process serves to increase trainee interaction among peers. The size of the groups depends upon the nature of the topic being covered.

Group work : Group work is an activity carried by a small group of trainees through pooling their collective thoughts, experiences and knowledge, together in order to perform a given task.

Mini Lecture : Mini-lecture is utilized in this manual to disseminate information directly from the trainer to trainees. This method when combined with other instructional strategies, promotes greater motivation and learning.

Module : A module is the basic unit of this training manual which covers a specific topic.

Objective : An objective is a statement of purpose for each module.

OHP : Overhead Projector (an audio-visual aid).

Overhead Transparencies : Overhead transparencies are used throughout the module as a visual aid to present and review information and to provide graphic examples. Overhead transparencies are acetate sheets on which information is written, drawn or printed and then projected through an overhead projector.

Role Play : Role Play is an activity which involves trainees in learning desired concepts or practicing certain behaviours. For example, one trainee takes the role of a counsellor and another takes the role of a client. Together they act a given counselling session. Role plays can be highly motivating because they actively involve the trainees. Using a video for recording the session and immediate feedback is a powerful adjuvant for training. Audio feedback is cheaper but less effective.

Review Questions: Review questions are questions posed at the end of each module and help to assess trainees' intake of knowledge covered during the sessions.

Worksheet : A worksheet is training material with instructions on the way to use it which is handed out to the trainees with an aim to sensitize or evaluate knowledge during a specific exercise.

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