HIV Counseling Handbook

एड्स विरुद्ध एकता
नेपाल

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Ministry of Health & Population
National Center for AIDS and STD Control
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Preface

Since the first case reported in 1988, HIV has gradually gone from being “low prevalence” to a “concentrated epidemic” in Nepal .

In order to combat this virus and challenges it bring to the people of Nepal, we have revised the HIV Counseling Training Package with recent guidelines and policies which aims to facilitate and assist our ART counselors as well as the frontline health workers who provide other health services to people living with HIV/ AIDS.

Further more, details regarding the nature and duration of the training will be provided shortly to all the participants.

On the behalf of NCASC, I would like to express my gratitude to every individual and /or teams involved in finalizing this training package and thank you all for your hard work which has helped this training package revision to be a success.

Dr. Sudha Devkota
Director, NCASC

Acronyms

ADC	AIDS Dementia Complex
ADLS	Activities of Daily Living
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Treatment
BBV	Blood-Borne Virus
CDC	US Center for Disease Control and Prevention
CNS	Central Nervous System
EIA	Enzyme-immune Assay
EID	Early Infant Diagnosis
ELISA	Enzyme-linked Immunosorbent Assay
ESSE	Exit, Survive, Sufficient, Enter
FBO	Faith-based Organization
FTM	Female to Male
GUS	Genital Ulcer Syndrome
HAART	Highly Active Antiretroviral Therapy
HBC	Health Behavior Communication
HBV	Hepatitis B
HCV	Hepatitis C
HCW	Health-care Worker
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HLA	Human Leukocyte Antigen
HPV	Human Papilloma Virus
HTC	HIV Testing and Counseling
IDU	Injecting Drug User
MARA	Most-At-Risk Adolescents
MARPS	Most-At-Risk Populations
MSM	Men Who have Sex with Men
MTF	Male to Female
NGO	Non-governmental Organization
NNRTI	Non-nucleoside Reverse Transcriptase Inhibitor
NRTI	Nucleoside Reverse Transcriptase Inhibitor
OI	Opportunistic Infection
OST	Oral Substitution Therapy
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PCP	Pneumocystis Carinii Pneumonia
PEP	Post-exposure Prophylaxis
PrEP	Pre-exposure Prophylaxis

PI	Protease Inhibitor
PITC	Provider-initiated Testing and Counseling
PLHIV	People living with HIV and AIDS
RIPA	Radio-immunoprecipitation Assay
STI	Sexually Transmitted Infection
SSRI	Selective Serotonin Reuptake Inhibitor
SW	Sex Worker
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Contents

Background

In Nepal, prevalence of HIV is driven among key populations (KPs) with a range of psychosocial issues including histories of drug or alcohol use, sex work, and gender and sexual identity. Besides the varied backgrounds of clients presenting at services, health care providers themselves might be of different professional backgrounds and are often challenged by a complex array of HIV-related psychiatric and psychosocial conditions. Counselors are expected to reduce transmission by facilitating knowledge of HIV status, provide psychosocial support, and address treatment adherence in the context of a still stigmatized disease. HIV counselors must meet these objectives with large numbers of clients, often with limited HIV counseling training, personnel support, and clinical supervision.

This handbook provides the following:

- An orientation to the role of an HIV counselor within HIV prevention, treatment, and care initiatives
- Guidance on practice ethics, including responses to common ethical challenges in HIV counseling
- A step-by-step guide to pre-test information on HIV for individuals or couples, and conduct group information sessions
- Assistance to individuals from key populations in reducing HIV transmission, adapting to HIV diagnosis, and improving the quality of their lives
- Ethical strategies for facilitating client disclosure of HIV status to children, partner(s) and family
- Assistance to clients in overcoming treatment adherence challenges
- Strategies in support of health-care workers who have sustained occupational exposure.
- Guidance in tailoring counseling to the diverse and specialized needs of clients affected by HIV throughout the country
- Guidance in establishing and implementing a peer supervision support network.

Chapter 1

Basic of HIV, Sexually Transmitted Infection (STIs), and Tuberculosis (TB)

A counselor will require to understand and communicate effectively to clients on following:

- How it is transmitted
- How it is diagnosed
- How the disease progresses
- How HIV treatments works

It is also important that counselors understand how STIs are transmitted, treated, and related to HIV. it is important that counselors understand the risk of TB infection among people living with HIV (PLHIV) and their role to address TB/HIV co-infection.

What is HIV Infection?

HIV (human immunodeficiency virus) is a member of the genus Lentivirus, which belongs to family Retrovirus. HIV has two major types: HIV type 1 (HIV-1) and HIV type 2 (HIV-2). HIV-1 is the most common and pathogenic strain of the virus. HIV-1 can be divided into groups: M, N, O and P. The epidemic is dominated by group M. HIV-1 and HIV-2 are transmitted in the same way and are associated with similar opportunistic infections, though they differ in the efficiency of transmission and rates of disease progression. HIV-2, found primarily in West Africa, appears to be less easily transmitted and progresses more slowly to AIDS than HIV-1. A person can be infected with both types of HIV simultaneously.

What is AIDS? How is it different from HIV?

AIDS is an acronym for “Acquired Immune Deficiency Syndrome”. Acquired means “transmitted from person to person”; immune is the body’s system of defense; deficiency means a “lack of” or not working to the appropriate degree; and a syndrome is a group of signs and symptoms. AIDS is the advanced stage of HIV infection. The human immunodeficiency virus (HIV) causes AIDS in humans after several years of HIV infection without treatment.

What is the immune system?

The immune system is a collection of cells and substances that defend the body against foreign substances, also known as antigens. An antigen is a substance (such as HIV) that, when introduced into the body, stimulates the production of an antibody (the word antigen is short for “antibody generating”; antibodies fight antigens). Antibodies form in a person’s blood when HIV or other antigens enter the body. Usually antibodies defend against disease agents. The replication of HIV in the body over time, and especially without pharmacological intervention, breaks down the immune system to the point where it can no longer fight disease. The immune system functions in a similar way. It is composed of cells (called T-lymphocytes and B-lymphocytes) that perform the role of police. Among the T-lymphocytes are cells that carry what are known as CD4 receptors. These cells are called T4 lymphocytes (or T-cells or CD4 cells).

HIV infects a person's CD4 and T-cells and uses them to make copies of it–a process known as replication. In a person infected with HIV, CD4 cells are progressively destroyed. As these cells are destroyed, an infected person's immune system is weakened and the person is more likely to develop opportunistic infections (OIs) and certain cancers. Any other infection that stimulates the immune system is likely to accelerate this destruction, making
the person more vulnerable. (Refer exercise book Fig 1.3)

How is HIV transmitted?

HIV is found in blood, genital fluid (semen, vaginal fluids,) cerebrospinal fluid, amniotic fluid, ascitic fluid and breast milk. It can be transmitted in any of three ways:

1. through unprotected sexual contact without use of condom (Anal, oral and vaginal sex) -
2. through blood and blood products: blood transfusion, organ transplant, sharing of needles by PWID, needle stick injury, tattoos
3. from infected mother to baby during pregnancy, during birth and during breast-feeding ;

Risk of infection depends on type of exposure

The chance that a person will become infected with HIV varies greatly depending on the type of exposure he or she has had. For example, the risk of becoming infected with HIV through a blood transfusion with infected blood is very high compared with the risk of becoming infected from an accidental needle prick in the health-care setting. Similarly, there is less risk of acquiring HIV from unprotected oral sex than from unprotected anal or vaginal sex.

Table1.1 the risk of HIV infection based on the type of exposure

Type of exposure	Risk in percentage
Percutaneous (blood)	0.3%
Mucocutaneous (blood)	0.09%
Receptive anal intercourse	1 - 2%
Insertive anal intercourse	0.06%
Receptive vaginal intercourse	0.1 – 0.2%
Insertive vaginal intercourse	0.03 – 0.14%
Receptive oral (male)	0.06%
Female-female orogenital	4 case reports
IDU needle sharing	0.67%
Vertical (no prophylaxis)	24%

Different behaviors carry different level of risk

It is important that the clients understand that HIV may be present in and transmitted by semen, vaginal fluids, breast milk and blood. To reduce risk among clients, they will need to understand that different behavior carry different levels of risk. HIV counselors must assess each client's understanding and impart relevant information depending on his or her needs and level of knowledge. Clients must be encouraged by counselors to make informed decisions about testing and behavior change. Such informed decisions require a clear understanding of the modes of transmission, the risk involved, and the implications of an HIV test result, as well as the correction of clients' misconceptions.

Sexual transmission is predominant mode of transmission of HIV

About 70-80% of global HIV transmission occurs through unprotected sexual intercourse between infected persons and their partners. The sexual contact may be heterosexual or homosexual. Heterosexual vaginal intercourse is the predominant mode of transmission in many developing countries including Nepal. While the probability of transmitting HIV in a single sexual act is quite low, even a lower-risk act can get HIV infection due to repeated risk behavior and exposure. Furthermore, the risk of infection can increase dramatically because of several factors, like anal sexual intercourse, high HIV viral load, existing STIs, (genital sores or discharge) and unprotected intercourse.

Transmission in clinical settings, injecting drug use, and tattooing

HIV infections resulting from transfer of infected blood accounts for about 5-10% of all HIV infections. Transmission can occur through transfusion with contaminated blood or blood products, (assessment of donors needs to done properly to minimize this). Organ transplants from infected donors can also transmit the infection, so screening of donor is required. Additionally, HIV can be transmitted through direct contact with instruments (not sterilized) that have been contaminated with infected blood like tattoo and piercing or sharing of needles by injecting drug users.

Transmission during pregnancy, delivery and breast feeding

A HIV infected mother can transmit HIV to her child during pregnancy or delivery or breastfeeding The rates of HIV-1 transmission from mother to child range from 25 to 40% in less-developed countries and from 15 to 25% in more-developed countries. The risk of transmission is affected by factors related to enrolment in treatment, ,adherence of mother to the ART, the delivery (prolonged, home delivery) , timely providing prophylaxis to newborn baby, and infant-feeding practices. Viral, bacterial or parasitic placental infections are other factors that increase the opportunity for transmission during this period. Most infants who acquire HIV during delivery are thought to have acquired it from maternal blood or cervical secretions that contain the virus. Prolonged membrane rupture and invasive delivery techniques have also been associated with higher risks of mother to child transmission (MTCT) during labour and delivery.

The risk of MTCT increases if a woman has a higher viral load, which occurs if she is diagnosed late with HIV, not enrolled in treatment or does not adhere to the treatment during pregnancy or if she becomes ill with AIDS.

After delivery, new born babies are provided ARV prophylaxis and to decrease the risk of acquiring HIV and on breast-feeding. The risk of transmitting HIV for children below 6 months of age through mix feeding increases, so it is advised to provide exclusive breastfeeding for initial six months of age or if complications develop from poor breast-feeding techniques (e.g., mastitis, cracked and bloody nipples).

Table 1.2 Timing of transmission of HIV from mother to child

Period	Population with no breastfeeding	Breastfeeding through 6 months	Breastfeeding 18-24 months
During pregnancy	5%-10%	5%-10%	5%-10%
During Labour	10%-20%	10%-20%	10%-20%
Through breastfeeding	-	-	-
Early (first 2 months)	-	2%-10%	2%-10%
Late (after 2 months)	-	1%-5%	5%-10%
Overall risk of MTCT of HIV	15%-30%	25%-35%	30%-45%

Source: de Cock K.et al. Prevention of mother-to-child HIV transmission in resource-poor countries: Translating research into policy and practice. JAMA 2000, 283: 1175-1182.

How is HIV diagnosed?

The diagnosis of an HIV infection is most often based on the detection of antibodies to the virus. An antibody test is rarely 100% sensitive (correctly able to categorize an infected person as positive) and 100% specific (correctly able to categorize a non-infected person as negative). Therefore, the Joint United Nations Program on HIV/AIDS (UNAIDS), the World Health Organization (WHO) and the US Centers for Disease Control and Prevention (CDC) jointly recommend that all positive test results be confirmed by retesting, preferably using a different rapids tests according to National algorithm National Testing and Treatment Guideline 2020 recommends providing positive test result only after getting reactive results with three tests kits with different testing methods. Eclipse period. This period refers to the period of first 10 days following:

HIV infection, during which currently available assays cannot detect any marker of HIV infection. The end of the eclipse period is marked by the appearance of HIV RNA or DNA, detectable by nucleic acid testing (NAT) and then HIV p24 antigen, detectable by immunoassay. After a week of detection of HIV antigen in the blood, HIV antibodies appear in the blood and antibody-based assays can detect HIV infection.

Acute HIV infection. Acute HIV infection is the phase of HIV disease immediately after infection, which is characterized by an initial burst of viraemia; HIV RNA or p24 antigen is present.

Window period. The period between HIV infection and the detection of HIV- 1/2 antibodies using immunological assays is the window period. This signals the end of the seroconversion period.. Within this time frame, however, HIV is replicating in the blood and lymph nodes. The virus can be detected in this early phase only by laboratory tests used to identify the virus itself. With third-generation HIV antibody tests, antibody can be detected after 21 days, the period of the first 21 days can be considered window period

Recent Infection : Any infection detected within 6 months of infection is considered as Recent infection.

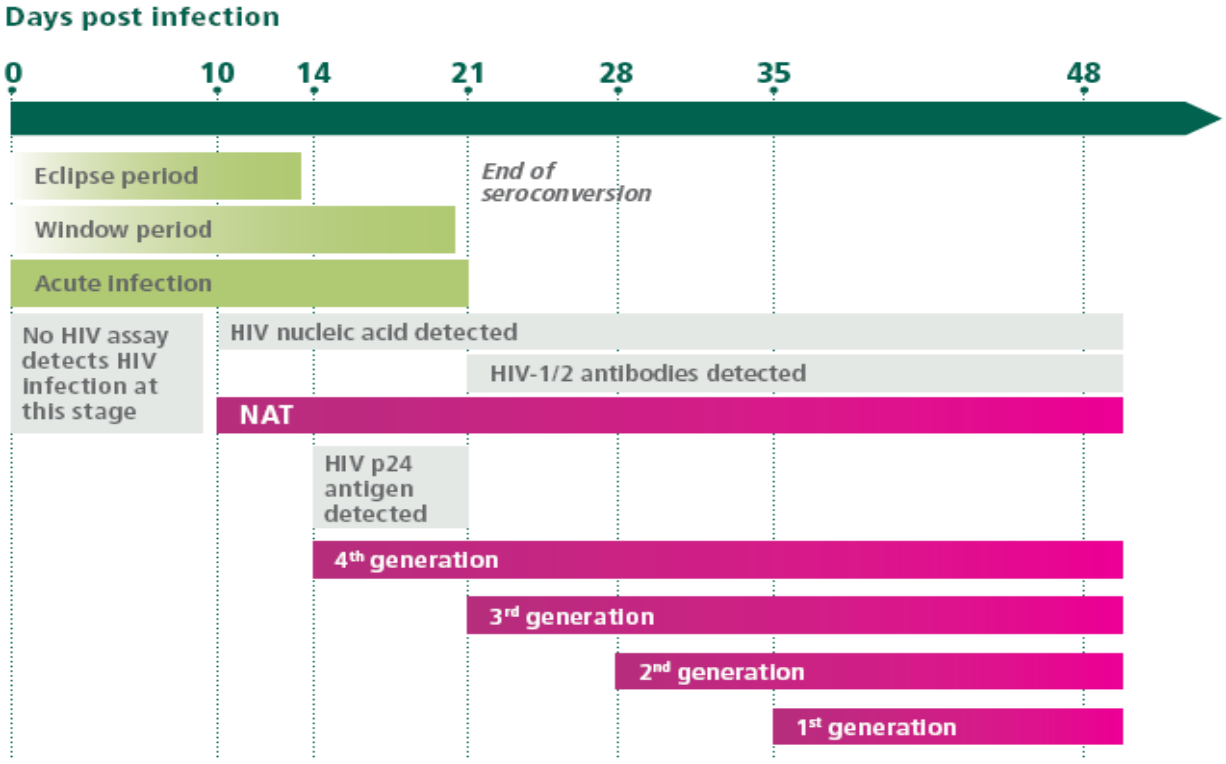


Fig. 1.1 Detection of HIV by different format of test

Types of tests

Different types of tests done at Nepal)

1. Antibody test
    - Rapid tests
    - ELISA
2. ECLIA (Electro Chemi Luminiscence Assay)
    - HIV-Combi test (can detect either Ag or Ab according to period of infection)
3. Virological tests
    - Polymerase chain reaction (PCR) (Qualitative: early infant diagnosis (EID) for diagnosis process and Quantitative : HIV-viral load.for monitoring process.

1. Antibody tests

Once HIV enters the body, it infects white blood cells, known as CD4 cells. The infected person's immune system responds by producing antibodies to fight the new HIV infection. The presence of the antibodies is used to determine the presence of HIV infection. In Nepal most commonly used antibody tests are :

a) Rapid tests detect antibodies against HIV; they do not directly detect the virus itself.
b) ELISA : detect antibodies against HIV; they do not directly detect the virus itself.

Rapid HIV testing

Rapid HIV tests are antibody tests that generally produce results in less than 30 minutes, and require only a few steps and a limited amount of training. While blood-based rapid tests (using blood drawn from a vein or taken from a finger-prick) are the most common.

In most rapid tests, whether blood-based or using serum or plasma, a sample is generally introduced into a sample collecting tubes or at the base of a strip (known as a lateral flow assay) and absorbed through or along a membrane.

If a patient has antibodies against HIV, these will be captured on the membrane and a latex- or gold-based indicator will be added to make the antibodies visible-usually as a band or a dot.
Most assays also include an additional control band or dot that becomes visible if the test was properly done.

As with all antibody tests, a positive result in any rapid test must be confirmed following National Testing Algorithm. However, oral fluid samples are not recommended for HIV diagnosis.

Recently Nepal has adopted HIV self-testing approach in the guideline recommends using oral fluid samples by using **OraQuick** test kit but this is only a screening method. All the reactive cases again must be confirmed using National HIV testing algorithm.

Nepal's Testing Strategy

Every country has its own strategy for HIV diagnosis. Nepal's HIV testing strategy uses rapid HIV antibody test kits for HIV diagnosis. More than one test kit is used in the order specified by the National testing and treatment guidelines, refer to latest National Testing and treatment guideline for testing algorithm is as follows

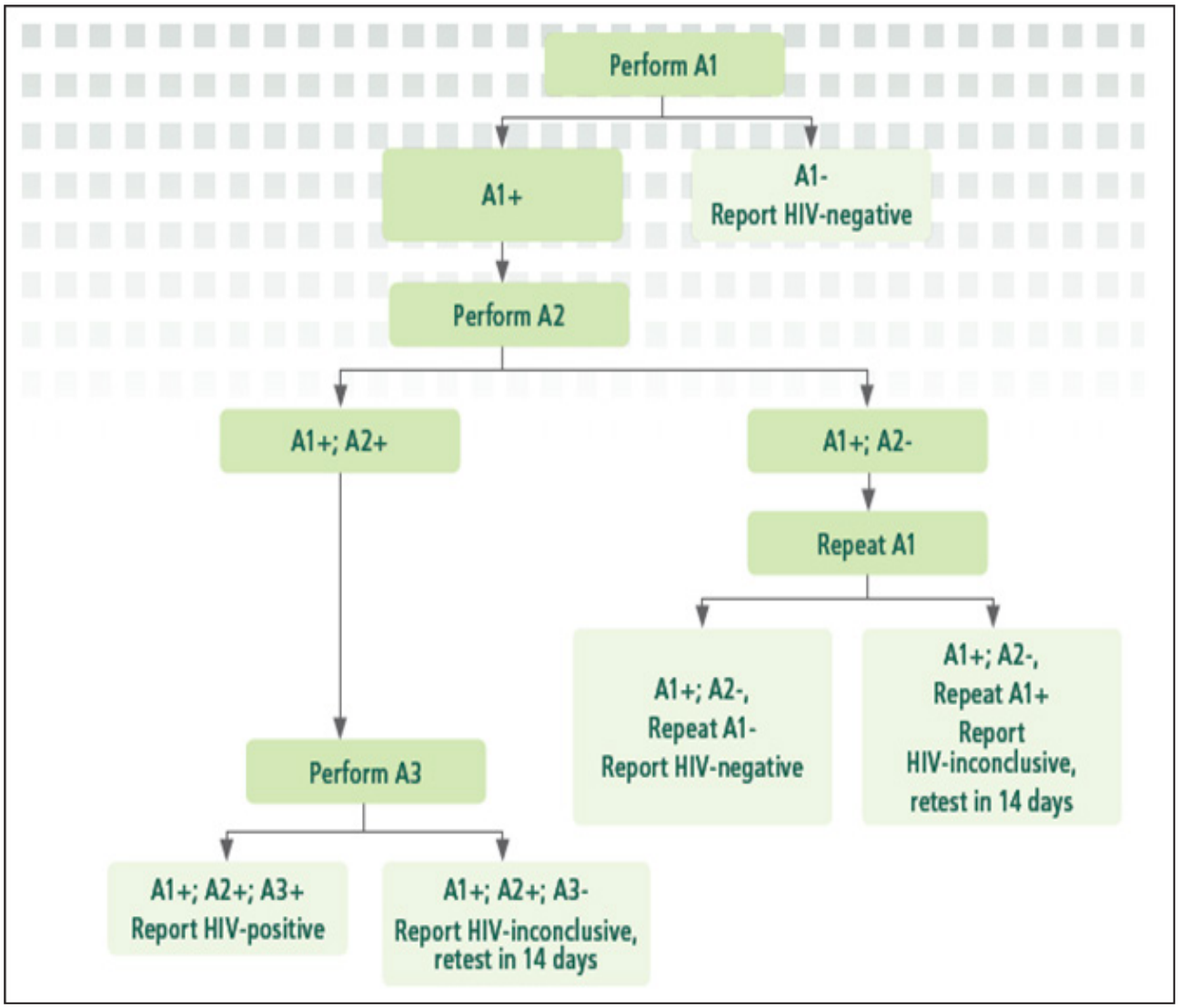


Fig.1.2 HIV testing algorithm

2. ECLIA

This test is four generation assay based on chemiluminiscence method and detects p24 Ag or HIV-Ab, (HIV-Combi test) . After the completion of Eclipse period (i.e after 2 weeks) it helps in the diagnosis of HIV infection either by detecting Ag or Ab or both.

3. Virological tests

The antibody tests discussed above are those most commonly used in HIV testing. Under special circumstances (e.g., in a recently infected individual, during the window period, or in the case of a child born to an HIV-positive mother), more direct diagnostic methods are required. Unlike antibody tests, virological tests determine HIV infection by directly detecting the virus itself. There are three types of virological tests:

1. Nucleic acid-based tests (specialized tests that look for genetic information on HIV through polymerase chain reaction or PCR It can be Qualitative (EID) as well as Quantitative (HIV viral load) and
2. Virus culture, which isolates the virus. (Not available in Nepal)

In Nepal, PCR based tests are available. Total Nucleic Acid (TNA) Amplification PCR is used to diagnose HIV in babies under 18 months of age and RNA PCR is used to monitor the response to therapy, it is commonly known as viral load tests. Sample for TNA PCR for infant diagnosis can be collected by a simple technique called “dried blood spot” or DBS. It allows sample collection in peripheral sites and problem free transportation (room temperature, sending via post in a paper envelope) to central laboratories for processing.

Testing infants and children for HIV

HIV diagnosis in infants is problematic because infants born to HIV-positive mothers test positive for antibodies as they acquire antibodies from their mothers during pregnancy and delivery. These antibodies remain in blood of child up to 18 months of age. A positive result with an antibody test during birth only identifies infants who have been exposed to the mother’s antibodies against HIV; these children may not be infected with the virus itself. So all HIV exposed children under 18 months of age need to be diagnosed by performing TNA PCR testing.

Early Infant Diagnosis

Diagnosis of HIV infection in babies born to HIV infected mothers cannot be confirmed by conventional antibody tests. The presence of anti-HIV antibody in the new-born may not necessarily indicate primary infection. It may be due to the presence of passively transmitted anti-HIV antibodies from the mother to the uninfected babies which may remain in blood of baby for up to 18 months. Hence, molecular assays such as HIV RNA PCR or total nucleic acid (TNA)-based assays should be used for diagnosis.

The following are the guiding principles of the National EID program:

a. Routine molecular test of all HIV-exposed infants at birth
b. Repeat the test of the child at six weeks of age (if the first test was identified negative)
c. Repeat the test of the child at 9 months of age (if the HIV exposed child was negative in first two test -at birth and six weeks of age)
d. Repeat the HIV testing of the HIV exposed children after 3 months of cessation breast feeding or if the child reached more than 18 months of age

Diagnostic algorithm for EID

a) Samples from HIV-exposed infants will be collected within 48 hours (at the earliest after birth) in dried blood spot (DBS).
b) All infants with non-reactive TNA PCR at birth will be retested at six weeks (as mentioned in the algorithm).
c) Infants with first reactive sample will be put on ART and another DNA PCR done to confirm the status. Two consecutive HIV-TNA PCR will be considered as positive HIV status.

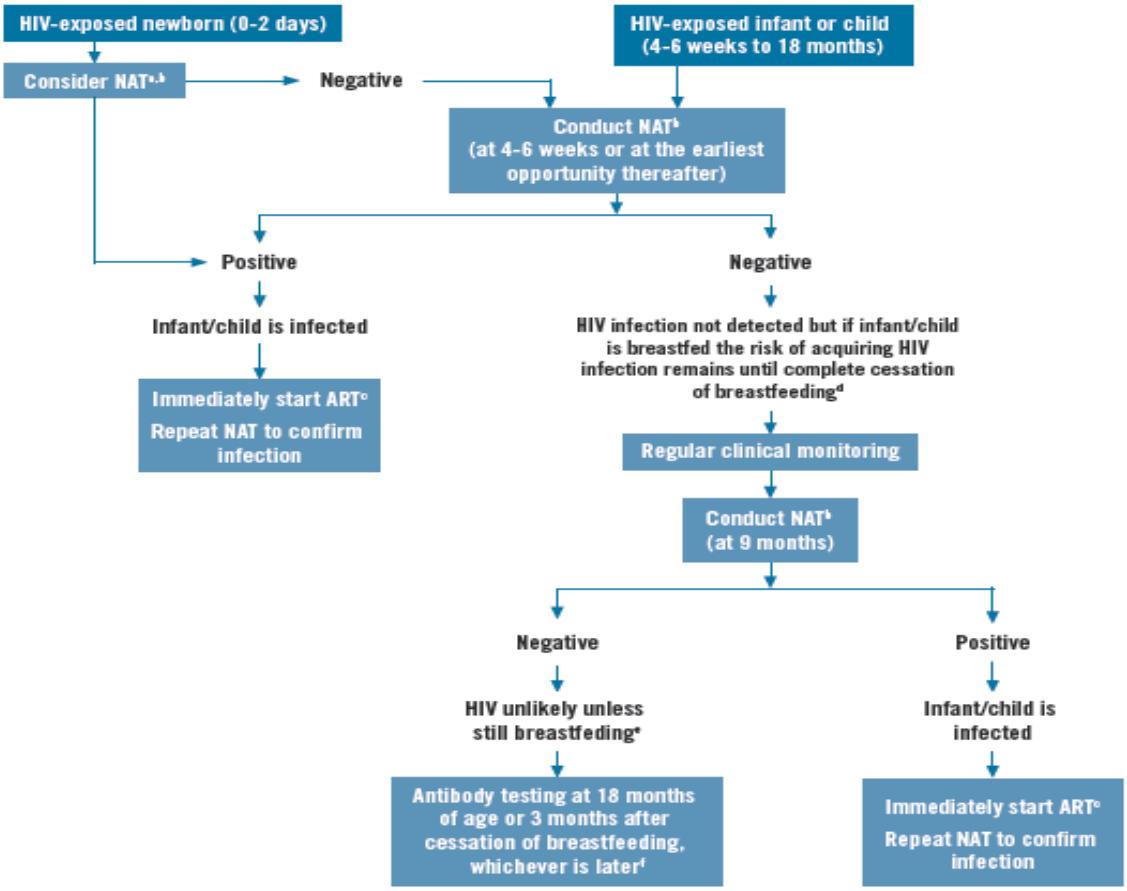


Fig 1.3 Diagnostic algorithm for EID

Interpreting HIV test results for infants and children

Positive HIV TNA PCR: A child with a positive molecular test at any age is presumed to be HIV-infected. Repeat the test to confirm infection status, but ART should be started immediately without waiting for the confirmation of the second test.

Negative HIV TNA PCR

The interpretation of a negative molecular test is dependent upon whether the child is breastfeeding.

- Children never breastfed: A single negative PCR test is likely to exclude HIV infection. An antibody test at 18 months should be done to confirm HIV status
- Children weaned more than 3 months prior to molecular test: A single negative PCR test is likely to exclude HIV infection.
- Children on breastfeeding at the time of molecular test: A negative HIV TNA PCR test demonstrates that the child is not infected at the time of testing. Confirmatory testing should be done more than three months after breastfeeding is stopped.

Intermediate: Intermediate range detection threshold will be 32-35 cycles by Roche® COBAS® Ampliprep/COBAS® Taqman Qualitative Test v2.0 assay (Policy brief, updated recommendation, July 2018, WHO). Requires repetition DBS sample for confirmation.

Approaches are needed to increase EID and timely referral of infants diagnosed as HIV positive to care and treatment. Both are key to improving health outcomes and child survival. The time taken for sample transport and turnaround time from laboratory need to be reduced using email/SMS for communicating the results.

Interpreting HIV test results

Only suitably trained and authorized personnel should interpret and provide the test results All counselors should, however, understand and be able to explain the meaning of a test result to a client.

A negative test result means that HIV antibodies were not detected in the person's sample, either because the person is not infected or because the person is still in the window period.

The client must also understand that a negative result does not necessarily mean that he or she is uninfected or immune to HIV infection. An HIV-negative person who engages in risky behavior is still vulnerable to HIV infection. A person who tests negative but has practiced unsafe behaviors during the window period may be infected with HIV and infectious to others. So, on retesting after 21 days of the risk behavior to provide.

A positive test result means that HIV antibodies were detected in the person's sample. The person is infected with HIV and can transmit the virus to others if he or she engages in risky or unsafe behaviors. It does not necessarily mean that the person has AIDS.

False-negative results

A false-negative result occurs in an infected person when the blood test gives a negative result for HIV antibodies even though it should have showed positive. The likelihood of a false-negative test result must be discussed with clients if their history suggests they have engaged in behavior likely to put them at risk of HIV infection. Repeated testing over time may be necessary before the client can be reassured that he or she is not infected with HIV. Most often a false-negative result arises among individuals who are newly infected and are not yet producing HIV antibodies. It is important to remember that someone who has rightly tested negative because he or she is not infected with HIV can become infected at any time afterwards.

False-positive results

The HIV antibody tests that are now available are extremely sensitive, and false-positive rates are appreciable, particularly in low-prevalence populations. Confirmatory tests usually rule out false-positive results. A false-positive on one assay is unlikely to test positive on a second, different type of assay. All clinical HIV testing strategies nevertheless require repeated HIV antibody assays. False-positive results may be due to technical error, repeated thawing and freezing of sample, and cross-reactivity.

In ELISA and rapid tests, human leukocyte antigens (HLAs) can cross-react, resulting in false-positives among persons with:

- rheumatoid arthritis,
- multiple sclerosis,
- systemic lupus erythematosus,
- type 1 diabetes mellitus,
- Addison's disease,
- ankylosing spondylitis,
- chronic hepatitis,
- cancer (particularly lympho-proliferative malignancies), or
- severe kidney disease

And in persons who have had:

- a flu shot in the past 30 days,

- a gamma globulin injection, or
- a recent transfusion or organ transplant.

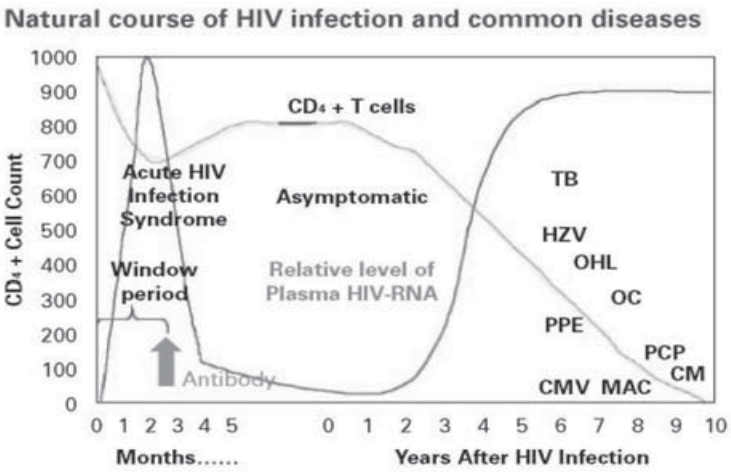
External quality assurance of HIV testing

All testing done at HTC centers should subject to external quality assurance. All positives and 10% of negative samples–venous samples or samples collected through a filter-paper method (commonly referred to as dried blood-spot specimens)–should be sent out for external quality assurance testing. For example, every positive samples and one of every 10 negative samples may be sent quarterly to a National Public Health Laboratory for quality assurance or periodic proficiency. The quality control protocols depend on National testing policies, HIV prevalence, the purpose of testing, and the number of different HIV tests available in a particular setting.

Recently, National Public Health Laboratory (NPHL) has implemented Proficiency Panel Test (PT panel) using Dried Tube Specimens (DTS). NPHL prepares DTS and distributes to different testing sites. All the testing sites will perform HIV testing of provided DTS and report result back to NPHL. At last NPHL will provide EQAS feedback.

HIV disease progression

After HIV enters a person's body, it infects the person's cells (essentially CD4 T cells and macrophages) and starts replicating. HIV induces the body's immune system to produce antibodies specific to HIV. As explained above, the period between the acquisition of the infection and the production of detectable HIV antibodies is called the window period and it can last anywhere from two to 12 weeks. During this period, an individual may have an acute HIV infection also sometimes referred to as a primary HIV infection. Here an infected person can be highly infectious despite having a negative HIV test result. At the time of infection, 30-50% of people have a recognizable acute illness characterized by fever, lymphadenopathy (enlarged lymph nodes), night sweats, skin rash, headache, and cough.



CM = cryptococcal meningitis, CMV = cytomegalovirus retinitis, MAC = *Mycobacterium avium* complex infection, OC = oral candidiasis, OHL = oral hairy leukoplakia, PCP = *Pneumocystis carinii* pneumonia, PPE = pruritic papular eruption, TB= tuberculosis.

HIV-positive individuals may remain without symptoms (asymptomatic) for up to 10 or more years. In this phase they are potentially a critical factor for the transmission of HIV, as they are infectious but can be identified only through blood screening for HIV antibodies. After a period that varies from person to person, viral replication resumes and with it the destruction of CD4 lymphocytes and other immune cells, resulting in a progressive immune deficiency syndrome.

Progression depends on a number of factors: the type of HIV infection, the person's age, other infections, and possibly genetic (hereditary) factors. Infections, diseases, and malignancies occur

among HIV-infected individuals and are related to the degree of immune suppression. These include morbidities such as TB, oral hairy leukoplakia, oral candidiasis, pruritic papular eruption, Pneumocystis carinni pneumonia (PCP) or Pneumocystis jiroveci, cryptococcal meningitis, cytomegalovirus retinitis, and Mycobacterium avium complex infection (see figure below).

WHO clinical staging

For people who present with clinical symptoms, diagnosis is usually based on the WHO clinical staging system, a four-stage classification system that combines signs, symptoms, and diseases, plus a physical activity framework using a performance scale. Clients are classified according to the presence of clinical conditions (opportunistic infections). The staging is hierarchical; once a stage is reached, the client cannot revert to a lower stage but can only progress to a higher stage.

Some countries have modified these criteria. Though counselors are not expected to make diagnoses, they must be aware of clinical staging to facilitate referral to medical providers for clinical management.

What does clinical management involve?

Individuals who are diagnosed with HIV should be referred to a HIV physician for ongoing medical follow-up. This follow-up may include regular immune system monitoring, antiretroviral therapy (ART), prophylaxis of OIs, the management of HIV related neurological and psychiatric conditions, the management of common co-infections including tuberculosis and hepatitis B and C, clinical examination, family planning, and general health care.

Immune system monitoring tests

Immune system monitoring tests are performed as part of HIV care and treatment and may include viral load and CD4 tests. The CD4 cell count is an indicator of the level of immune function at any given time, while the viral load is a measurement of the level of circulating virus in the blood. As the virus reproduces, it destroys CD4 cells and reduces the CD4 count. In general, the higher the viral load, the more quickly the CD4 cells are destroyed.

Like CD4 counts, viral load measurement is important for monitoring.

Persons with a high viral load are more likely to progress rapidly to AIDS than persons with a lower viral load and has risk of transmitting HIV to the partners than those with undetectable VL. Both tests are useful in guiding the effectiveness of ART, and determining a patient's prognosis.

Antiretroviral treatment

ART refers to medication that stops or inhibits the replication of HIV. Antiretroviral treatment in general is aimed at prolonging and improving the quality of life by maintaining the maximal suppression of HIV replication for as long as possible. ART drugs are taken in combination (three or more drugs) to suppress different stages of the life cycle of the virus. National testing and treatment Guidelines recommends on when to initiate ART, how to provide ART, managing side effects and other issues related to ART. Tool 8.2 contains a discussion on how ART works.

Prevention and management of opportunistic infections

An individual with a low CD4 count is susceptible to OI. The prevention and treatment of OI decreases the mortality risk of HIV infection. Individuals with low CD4 counts are prescribed preventive medications called OI prophylaxis. Common OIs in HIV are:

- TB;
- recurrent fungal infections in mouth and throat;
- skin diseases (e.g., Herpes infection); and
- STIs.
- pneumonia (usually PCP);
- meningitis;
- septicemia;

The three most commonly reported OIs in Asia are TB, PCP, and extra-pulmonary Cryptococcus (usually meningitis). The clinical management includes management of specific OI's and nutritional and support.

Management of HIV-related neurological and psychiatric conditions

HIV-related neurological and psychiatric disorders are the result of direct or indirect effects on the brain of either HIV or complications from the suppression of the individual's immune system, such as OIs. These disorders may include one or more of the following:

- mania;
- depression;
- personality change;
- psychosis;
- HIV minor cognitive disorder; and
- HIV dementia (also referred to as AIDS dementia complex),
- HIV encephalopathic disorders that affect motor skills, coordination, and balance.

While new treatment strategies have resulted in marked improvements in health, mental health care is increasingly recognized as crucial to the overall health of all people with HIV. Psychological well-being affects one's overall health and, importantly, also ensures that treatment decisions are adequately considered, adherence to ART is optimized, and behavior changes needed to reduce HIV transmission can be initiated and maintained.

Management of tuberculosis co-infection

Among PLHIV, TB is the most frequent life-threatening OIs and a leading cause of death accounting for about a third of all mortality. The lifetime risk of someone with latent TB developing TB disease in HIV negative individual is 5–10%, whereas in a HIV positive individual it is up to 50% or 10% a year. ART should be provided to all PLHIV with active TB disease along with TB treatment. Managing TB among HIV-infected individuals, thus, is one of the major responsibilities of the ART clinician.

TB could be prevented in millions of people infected with HIV. Using TB preventive treatment (TPT) is an important intervention for preventing and reducing active TB in communities affected by HIV. TPT is also one of the key interventions recommended by WHO in 2018 to reduce the burden of TB in people living with HIV.

Screening for active TB should be performed for all new HIV-infected clients at their first visit using a TB screening questionnaire, a full initial history and physical examination and symptom screening should be continued at each visit (Each time the HIV patients visit the health facility for care, treatment or ART re-fill).

Active tuberculosis must be excluded before beginning TB preventive treatment. All individuals living with HIV should be screened with the following clinical symptoms:

Symptoms suggestive of TB in adults and adolescents and children living with HIV are:

1. Current cough or
2. Fever or
3. Unexplained weight loss in adults and adolescents and poor weight gain in children (<10 yrs of age)
4. Night sweats

The clinical screening becomes more difficult to apply in younger children. Ask for history of contact with TB cases particularly bacteriologically confirmed cases. This is usually a requirement to give TPT in infants (<1yr) living with HIV.

Absence of all four of these signs and symptoms is usually a reliable way of excluding active TB in adults and adolescents (>10 years of age or more) living with HIV. Use of chest radiography is not routinely required in this age group to exclude active disease.

Tuberculin skin test (TST) /IGRA is not a requirement for initiating TPT in people living with HIV. People living with HIV who have a positive TST/IGRA benefit more from TPT; TST or IGRA can be used where feasible/available to identify such individuals.

Who should receive TPT:

- Adults and adolescents living with HIV who are unlikely to have active TB should receive TB preventive treatment as part of a comprehensive package of HIV care. Treatment should also be given to those on antiretroviral treatment, to pregnant women and to those who have previously been treated for TB, irrespective of the degree of immunosuppression and even if LTBI testing is unavailable.
- Infants aged < 12 months living with HIV who are in contact with a person with TB and who are unlikely to have active TB on an appropriate clinical evaluation or according to national guidelines should receive TB preventive treatment.
- Children aged ≥ 12 months living with HIV who are considered unlikely to have active TB on an appropriate clinical evaluation or according to national guidelines should be offered TB preventive treatment as part of a comprehensive package of HIV prevention and care if they live in a setting with high TB transmission, regardless of contact with TB.
- All children living with HIV who have successfully completed treatment for TB disease may receive TB preventive treatment. TPT may be started immediately after the last dose of TB curative treatment or later among adult and children living with HIV following clinical judgement.

How should the screening be done?

- Adults and adolescents living with HIV should be screened for TB according to a clinical algorithm. Those who do not report any of the symptoms of current cough, fever, weight loss or night sweats are unlikely to have active TB and should be offered TB preventive treatment, regardless of their ART status.
- Adults and adolescents living with HIV who are screened for TB according to a clinical algorithm and who report any of the symptoms of current cough, fever, weight loss or night sweats may have active TB and should be evaluated for TB (Fig 7.2).
- Chest radiography may be offered to people living with HIV and on ART and preventive treatment given to those with no abnormal radiographic findings.
- Infants and children living with HIV who have poor weight gain, fever or current cough or who have a history of contact with a person with TB should be evaluated for TB and other diseases that cause such symptoms. If TB disease is excluded after an appropriate clinical evaluation

or according to national guidelines, these children should be offered TB preventive treatment, regardless of their age.

Management of sexually transmitted infection

STIs are particularly prevalent in developing countries and among sexually active young people. Some of the most common STIs are gonorrhoea, syphilis, genital herpes, Chlamydia, human papilloma virus (HPV), and trichomoniasis. Different pathogens are responsible for each STI.

If left untreated, STIs can have serious consequences for men, women, and newborn children.
STIs are a powerful co-factor in HIV transmission. Their presence makes a person more vulnerable to HIV by a factor of 15%-20%. Genital lesions or inflammation caused by STIs enables HIV to enter and establish itself in the body. STIs, particularly if they are ulcerative, increase one's risk of contracting HIV because they may cause ruptures or micro-lesions in mucous membranes. Thus, to reduce the risk of HIV infection, one must avoid contracting other STIs. If other STIs do occur, they must be treated promptly and effectively to minimize the risk of acquiring or transmitting HIV. We will take a closer look at STIs later in this chapter.

Management of hepatitis B and C co-infection

Hepatitis B (HBV) and hepatitis C (HCV) co-infection are seen in Nepal also. HBV transmission is similar to HIV transmission. HCV, on the other hand, is transmitted by infected blood products and donated organs and through the sharing of injecting equipment. Both HBV and HCV cause liver inflammation, which may complicate the patient's HIV treatment. Counselors should therefore urge their clients to be tested for the presence of these infections. Patients with HBV or HCV should be counselled to avoider limit their alcohol intake to prevent liver damage.

STI

For the reasons discussed above all HIV counselors should be familiar with STI , treatment, and care. STIs are acquired through heterosexual or same-sex relations. Another means of transmission is from mother to child during pregnancy (syphilis) or delivery (gonorrhoea, Chlamydia). The same behaviors that put individuals at risk of HIV infection also expose them to risk of acquiring other STIs: having multiple sex partners or high-risk partners, and engaging in unprotected sex. Thus, the prevention methods are the same.

Clinical manifestations of STI

Many STIs have similar clinical manifestations, with minor variations. Consequently, STIs can be categorized by either their signs and symptoms or their causative agents. Classification according to signs and symptoms has facilitated syndromic treatment, which does not rely on laboratory tests. This approach is useful in resource-constrained settings.

Table 1.3 summarizes the signs and symptoms of the six most common STI syndromes.

STI Syndrome	Signs/symptoms	Common causes
Urethral discharge (in men)	Urethral discharge Urethral itching Pain on urination Frequent urination	Neisseria gonorrhoeae Chlamydia trachomatis
Scrotal swelling (complication of untreated urethral discharge)	Scrotal pain and swelling	Neisseria gonorrhoeae Chlamydia trachomatis
Genital ulcer disease syndrome (GUD)	Genital ulcer with or without pain Swelling of inguinal lymph nodes Abscess and/or fistula	Treponema pallidim Haemophilis ducreyi Genital herpes Klebsiella inguinale Chlamydia trachomatis (serovars L1-3- Lymphogranuloma venereum)
Inguinal bubo	Swelling of inguinal lymph nodes Abscess and/or fistula	Haemophilis ducreyi Chlamydia trachomatis (serovars L1-3- Lymphogranuloma venereum)
Vaginal discharge syndrome (in women)	Vaginal discharge Painful urination Dyspareunia Vaginal itching Frequent urination	Neisseria gonorrhoeae Chlamydia trachomatis Bacterial vaginosis Candida albicans Trichomonas vaginalis
Lower abdominal pain syndrome (complication of untreated endocervitis)	Pelvic pain Abdominal tenderness Fever	Neisseria gonorrhoeae Chlamydia trachomatis Anaerobic bacterial infection
Neonatal conjunctivitis	Purulent eye discharge Swollen eyelids Baby unable to open eyes	Neisseria gonorrhoeae Chlamydia trachomatis

STI Syndrome Signs/symptoms Common causes

STI care and treatment should consist of:

- correct early diagnosis, followed by treatment with antibiotics;
- and education for behavior change; and
- Treatment of all partners (sexual contacts).

STI and clinical management pose several challenges. Counselors' should consider the following in supporting STI treatment and care:

- It is difficult to change sexual behavior. Knowledge does not automatically lead to behavior change. STI control is difficult because sexual practices are rooted in everyday life and culture. Counselors should let their clients know that they can help them make these changes.
- People find it embarrassing to discuss sex. Sometimes people are shy about asking for the information they need, slow in seeking treatment, or reluctant to discuss the issue

with their partners. People can feel uncomfortable talking about sex and the subject is sometimes taboo. Counselors should carefully explain to the client or patient why discussing these sensitive issues are so critical.

- Many people with STIs exhibit no symptoms. People with STIs can spread infection even without knowing they are infected. Counselors should refer all clients' presenting with transmission risks for STI screening.
- Treatment is not always available, easy, or effective. Counselors can support clients in initiating and maintaining treatment adherence (see box 1.1 below).

Box 1.1: Key STI messages for clients

1. If you have multiple partners, have a check-up regularly. You can have an STI without having Symptoms!
2. Having an STI can put you at greater risk of getting HIV or giving it to others.
3. DO NOT ENGAGE IN SELF-TREATMENT! Specific drugs are needed for specific c STIs.
4. Therefore, only a trained STI doctor will know what medication is right for you and your condition.
5. Take your STI medication for the entire course even if your symptoms disappear. Otherwise, your STI may come back. Also, take the medication in the correct dose, in the correct way, at the correct time.
6. Find a way to tell your partners! If you are treated, but your partner is not treated and you have sex with them, you are at risk of getting the STI again (re-infection). Partner treatment is essential.
7. Many STIs can be transmitted from mothers to babies and can cause serious health problems in the infant.
8. When you have HIV it is even more important for you to have regular STI check- ups. Let your HIV doctor know what STI medications you are taking.

Chapter 2

Key Elements of Counseling

This chapter gives the reader an overview of what is involved in ethical and effective HIV counseling and reviews some basic counseling micro-skills and counseling service documentation.

What does HIV Counseling involve?

The key aims of HIV counseling are:

- to prevent HIV transmission by providing information about transmission risks (such as unsafe sex or needle sharing);
- to assist people in developing the personal skills needed to negotiate safer practices;
- to provide psychological support to people who are infected with and affected by HIV in improving their emotional, psychological, social, and spiritual well-being; and
- to support clients in treatment adherence.
  HIV counseling may also include one or more of the tasks outlined in the sections below. While counselors engage in direct client counseling as a major part of their key role, they are also often required to act as interagency liaison, conduct behavioral or clinical research and welfare assessments, train and supervise volunteers, prepare HIV community service plans, and engage in client advocacy, among other roles and duties.

Types of HIV counseling

➢ **HIV prevention counseling: HIV transmission risk reduction**

The counselor assists infected and uninfected clients in identifying and exploring the difficulties involved in reducing transmission risk behavior. Counselor may use a variety of strategies ranging from the simple provision of information to the more therapeutic evidence-based strategies that can include motivational interviewing, structured problem solving, interpersonal and brief psychotherapy for risk reduction, cognitive behavioral therapies, relationship counseling, and infant-feeding counseling. Prevention counseling is employed in pre-HIV test and post-HIV test counseling and in counseling across the disease continuum. It is recognized that it is difficult for clients to sustain changes in behavior over extended periods of time. When providing counseling across the disease continuum, counselor must continually assess the challenges that will face their clients as they strive to maintain behavior changes, and provide practical strategies that can help address these challenges. To change behavior in the context of drug or alcohol dependency, for example, counselor must assess whether the client is dependent (substance abuse) and whether he or she can implement harm reduction and substance dependency management strategies.

➢ **Pretest counseling/ group information**

Pretest counseling is confidential counseling that will enable an individual/group to make an informed choice about being tested for HIV. According to WHO guidance, this decision must be left entirely to the individual and must be free of coercion. To make an informed choice about testing, an individual needs to consider the potential benefits and risks associated with testing. His or her personal risk history must also be considered. The counselor supports the client in managing the potential risks and difficulties by considering the possible psychosocial, legal, and health implications of knowing

the client's serostatus. The counselor also assesses the client's capacity to cope with the possibility of a positive HIV antibody test, provides information on HIV, and engages in prevention counseling, mainly to reduce transmission risk behavior and thereby reduce the risk of HIV transmission.

While individual one-to-one counseling offers the best standard of support to clients, alternative models of providing pre-HIV test information are also available. Pre-HIV test counseling may be offered to couples; this is discussed at greater length in chapter 4. In some situations where there are many clients or where the HIV test is offered as part of provider-initiated testing and counseling (PITC) and opportunities for one-on-one counseling are limited (because of time or human resource constraints), group pretest information may be offered. Information can be given in a group, but the informed consent component must always take place in a one-on-one setting to ensure that the patient's choice is autonomous and not coerced. These alternative forms of receiving pre-HIV test counseling are discussed further in chapter 4.

- **Post-HIV test counseling**

Post-test counseling is done primarily to ensure that individuals understand the meaning and implications of their test results. If the client tests positive for HIV antibodies, post-test counseling must make it easier for him or her to adapt to life with HIV and STI infection. Suicide presents a significant challenge to counselor. There are two periods when people with HIV are more likely to attempt suicide. When the person is first diagnosed, suicide may occur as an impulsive response to the emotional turmoil that follows. The second period of high risk occurs late in the course of the disease when complications of the nervous system resulting from AIDS develop, capacity to earn income declines, and people feel they are a burden to family members and care takers. Consequently, after the diagnosis counselor are required to conduct suicide risk assessments and to manage suicidal thoughts throughout the course of illness.

Post-HIV test counseling is typically provided by the counselor who conducted the pretest counseling. However, a counselor may have to provide counseling to an individual who was tested without his or her knowledge and consent. Counselor providing post-test counseling under the latter circumstances may report having to manage client anger, which is often projected onto the counselor.

- **Ongoing counseling for people affected by HIV**

The chronic and progressive natural history of HIV infection means that the psychosocial issues confronting both infected and affected individuals change throughout the course of the illness. In addition to issues directly related to HIV, patients may present with a range of psychosocial problems that are pre-morbid or only indirectly related to HIV. For many, becoming infected with HIV reactivates previously unresolved issues such as acceptance of sexual orientation, specific traumatic events such as sexual assault, or unresolved relationship problems. Infected and affected individuals may also need practical assistance such as referral to welfare services, liaison with caregivers, the preparation of wills, and the organization of substitute care for children. Counselor must work with multiple clients who present a range of problems that vary across the disease continuum.

- **Treatment adherence counseling**

Patients are confronted with many difficulties when required to take medication. Those taking medication for HIV, TB, STI, or hepatitis in particular must deal with many psychological, physical, and practical barriers to treatment adherence. Non-adherence can lead to inadequate suppression of bacteria and, in the case of HIV, viral replication. Counseling for treatment is provided to improve the patient's knowledge of both the disease and the medications and their side-effects. Counseling

helps the patient set goals, develop positive beliefs and perceptions, and increase self-efficacy in maintaining treatment.

- **Pediatric counseling**

HIV infection has a profound impact on the lives of children and their families. Not only do children have to cope with the physical aspects of ongoing illness due to HIV immune-related deficiency and its associated treatments, but they also suffer from the emotional and social effects of chronic illness and impending death. Counselor must often provide support to children to understand HIV infection, importance of treatment and assisting them in coping with separation and loss issues related to the parents' or the child's own illnesses. Other common presentations seen in children with HIV infections are behavioral disturbances, cognitive and motor impairment, and poor treatment adherence. Counselor caring for HIV-positive and HIV-affected children often have to support them in responding to stigma and discrimination. The pediatric and disclosure of status is not a single day procedure and has to be planned who and how would the be provided (in detail please refer to chapter 12). Furthermore, in many endemic areas counselors must assist children who have taken on a parental role to care for younger orphaned siblings. HIV counselor provide various forms of support to a child to ease his or her entry into substitute-care settings. The tasks may include working with substitute careers to understand how to give emotional support to children who have experienced not only the death of parents but also societal rejection or discrimination. Additionally, the counselors are often required to facilitate HIV testing and counseling of children to be adopted. Those found to be infected with HIV often fail to be adopted or fostered once they are diagnosed with the disease.

Children who present with HIV may have other psychological conditions associated with child sexual assault, child trafficking (including the selling of children into child labour), or experience in the military or with prostitution. In some situations physical abuse in association with the disclosure of the child's HIV status within communities and schools is also an issue.

Where is HIV counseling provided ?

HIV testing and counseling may be offered in a diverse range of settings including testing and counseling centers that are free-standing or integrated into hospitals, STI service centers, outpatient clinics, and a diverse range of health outreach or community-based programs. Counseling alone may also be offered as part of mobile or outreach services. It is preferred to be integrated with care and treatment service so that all HIV positive identified get enrolled into care and treatment immediately.

Who can provide HIV counseling ?

Not every person who practices counseling skills can be considered a counselor. Two broad groups of people use counseling skills: those who engage in counseling as a distinct occupation and those who use counseling skills as part of another occupation. The wide range of people who may play a role in providing HIV counseling services includes:

- nurses, doctors, social workers, and other care providers who have been specially trained in HIV counseling;
- full-time counselor (including psychiatrists, psychologists, and family therapists) who have been trained in HIV counseling;
- community-based workers whose work consistently entails appropriate handling of confidential information and emotional issues; and
- PLHIV

It is essential, however, that counselor have the specific training needed to support the different services they will have to provide. Increasingly, governments are requiring prospective counselor to undergo standardized national training irrespective of their professional background.

Developing your skills in effective HIV counseling

We have discussed the various types of HIV counseling and the tasks of counselor. In order for counselor to perform these tasks effectively, they must first understand what counseling is and what it is not, and also develop some basic skills. It must also be emphasized that counseling skills cannot be learned simply by reading a text. These skills must be rehearsed in a specialized training program under the supervision of an experienced counselor.

Counseling is goal-oriented interaction

Counseling is interaction between a counselor (helper) and another person or persons whom the counselor offers the time, attention, and respect necessary to explore, discover, and clarify ways of dealing with a problem. In the context of HIV and AIDS, counseling is a confidential dialogue between a client or patient and a counselor aimed at enabling the client to cope with stress and make personal decisions related to HIV.

- Counseling is based on a set of techniques and skills that the counselor brings to the interaction to help the client to explore and better understand a problem, deal with related feelings and concerns, evaluate alternatives, make choices, and take action.

Counseling is an issue-centered and goal-oriented interaction. It involves carrying on a dialogue and providing options for decision-making and behavior change. Effective counseling helps another person to be autonomous (able to choose, decide, and be responsible for his or her own actions).

Elements of ethical and effective counseling

Effective counseling has several agreed elements, as discussed below.

Ample time

Providing the client with adequate time is important from the very beginning. The counseling process cannot be rushed. It takes time to build a supportive relationship.

Acceptance

Counselor should not be judgmental of clients. Rather they should try to accept clients, regardless of socioeconomic, ethnic, or religious background; occupation; sexual orientation; gender identification; and drug or alcohol use.

Accessibility

Clients need to feel they can ask for help at any time. Counselors need to be available to clients at appropriate times and should have systems in place to respond to clients' needs as appropriate (e.g., provide services after hours or work during lunchtime on a rotating system). It is important that counselor maintain appropriate boundaries in their after-hours contact with clients. They must also maintain appropriate professional distance (e.g., counselor should not provide their home contact information to clients) and should not enter into non-professional relationships with their clients, especially sexual relationships.

Consent

Clients must be given an opportunity to consent to or decline HIV testing, treatments, or procedures in an informed and voluntary manner. Counselor facilitates the informed decision-making of their clients by offering clear and accurate information, and assisting clients in weighing the perceived benefits and risks of each intervention offered.

Consistency and accuracy

Information provided through counseling (e.g., about HIV infection, infant-feeding options, infection risk, risk reduction, and treatments) should be consistent with recognized scientific research and national HIV guidelines.

Confidentiality

Trust is the most important factor in the counselor-client relationship. It enhances the relationship and improves the odds that an individual will act decisively on the information provided. Given the discrimination, ostracism, and personal recrimination that an individual diagnosed with HIV may have to face, it is all the more important to guarantee confidentiality. Where the counselor is required by law or public health policy to provide information to a third party against a client's wishes, he or she should discuss with the client the reasons for doing so, along with the relevant process and procedures.

Sociocultural considerations

Effective and ethical counseling must recognize the impact of culture on a client's perception of the world. Counselor should take a holistic view of clients and their sociocultural background, including beliefs about HIV, sexual mores, traditional healing practices, gender inequalities, marriage practices (e.g., monogamy, polygamy), customs, and social practices. Counselor should keep in mind that culture and tradition shape attitudes and beliefs, particularly regarding illness and death. Thus, they should be sensitive to and respect cultural differences. A counselor should refer clients to another counselor if differences of gender, race, ethnicity, religion, sexual orientation, disability, or socioeconomic status interfere in any way with counseling.

The goal of counseling is to explore, discover, and clarify ways of living more resourcefully. To achieve this goal, counselor needs certain interpersonal and communication skills.

Interpersonal skills

Interpersonal skills are the skills that we employ to establish relationships.

Establishing rapport

Establishing rapport with clients is crucial in all counseling situations and is key to developing a trusting relationship. Developing rapport demonstrates the counselor's interest in and respect for a client's issues and concerns. Building rapport is an ongoing process that can be facilitated through:

- clarification of the counselor's role by the counselor during the first counseling session;
- respect and non-judgmental attitude;
- the presence of common or complementary goals;
- open verbal and non-verbal communication; and
- Mutual trust.

To establish rapport, one useful technique is to ask questions such as, ”What’s the worst thing that could happen?” or ”If we could deal with only one thing today, what would be most important to you?” Such questions help define and prioritize a client’s agenda and may be particularly appropriate at the start of a session. Furthermore, through this process the counselor is able to encourage the client to be explicit in describing sensitive issues, including sexual behavior patterns.

Ensuring privacy and confidentiality

Cross-cultural research indicates that clients in all cultures need to be assured of privacy and confidentiality. The counselor can ensure privacy and confidentiality by:

- providing adequate and appropriate space for counseling to take place;
- understanding that no information about a client can be divulged without the client’s consent;
- maintaining adequate records of any work with a client and taking all reasonable measures to preserve the confidentiality of the information;
- ensuring that colleagues, staff members, and trainees understand and respect the need for confidentiality in counseling services; and
- being aware that notions of shared confidentiality and partner notification often raise an ethical dilemma in the context of HIV counseling. (The term shared confidentiality refers to confidentiality that is shared with a limited number of people, such as family members, loved ones, caregivers, and trusted friends. This is provided only with the consent of the person undergoing testing, counseling, or treatment.)

Showing respect

Counselor need to understand that each person perceives and copes with predicaments in uniquely personal ways determined by numerous factors including culture, social class, and personality. Recognizing the fundamental rights, dignity, and worth of all people is critical. This can be achieved when counselor are aware of cultural and role differences in gender and gender identity, race, ethnicity, religion, sexual orientation, disability, and socioeconomic status, and work to eliminate their own personal prejudices and biases about such differences. Counselor must not participate in or condone discriminatory practices based on these differences. They must respect clients’ views and beliefs.

Furthermore, counselor should be aware that their own attitudes and actions can convey respect or the lack of it. The following actions help demonstrate respect for clients:

- helping clients make informed decisions about their lives and supporting them through the process (without, however, making demands or telling them what to do);
- keeping appointments and apologizing for being late or failing to keep an appointment;
- being a guide/facilitator and not a preacher;
- showing concern for clients’ welfare;
- seeing each client as a unique individual;
- seeing clients as capable of determining their own fate; and
- assuming that they can count on the good will of their clients unless and until the clients demonstrate otherwise.

Showing empathy

The ability to empathize is one of the most essential counseling skills. Empathy involves identifying with the client, understanding his or her thoughts and feelings, and communicating that understanding

to the client. For a counselor to communicate understanding of a client's world, he or she must enter that world (understand the client so well that the counselor feels like the client). Simply stated, this means that counselor should put themselves in their clients' shoes. Empathy requires sensitivity and a moment-to-moment awareness of a client's fear, rage, tenderness, confusion, or whatever else the client may be experiencing. To understand what the client is feeling, the counselor must be attentive to his or her verbal and non-verbal cues. The counselor needs to ask himself or herself, What feelings is the client expressing? What experiences and behaviors underlie these feelings? What is most important in what the client is saying to me?

Acknowledging difficult feelings

The presence of difficult feelings is a substantial and unavoidable component of counseling. To help address difficult feelings, counselor should:

- be aware of their own feelings;
- acknowledge clients' feelings and realities;
- understand that it is not the counselor's job to "remove" or "fix" feelings;
- articulate and respond to non-verbal messages; and
- normalize and validate clients' feelings.

While counselors may want to resolve problems and "fix" feelings, most often this is neither possible nor desirable. Rather, such negative feelings need to be acknowledged. Examples of statements that acknowledge a client's feelings are: "This must have been hard to deal with" and "So you believe that he cares for you, but it hurts to think about him having sex with someone else."

Offering acceptance

For clients to be honest in describing their problems and concerns during counseling, it is critical that he or she feel accepted. The counselor can facilitate this by being non-judgemental and accepting, irrespective of socioeconomic, ethnic, or religious backgrounds; occupation; sexual orientation or behavior; or personal relationships. Counselor should appreciate the stress caused by the fear of being infected or the need to change behavior, and accept the consequent emotions and reactions. Even if hostility is directed towards the counselor, he or she should recognize that they are not the real target and refrain from reacting (except to avoid physical harm). To validate acceptance, the counselor recognizes feelings such as anger, sadness, and fear in a direct, unemotional way, indicating in words and behavior: "Your feelings are very strong. I accept them, and I accept you."

Counseling communication skills and techniques

A major component of a counselor's job is communicating with clients. This exchange is a two-way dialogue using both verbal and non-verbal communication methods. To identify a client's needs and provide appropriate information; counselor must have solid communication skills. They must hear and understand the client's message and be clear in their own communication with the client. The following skills are important in building effective communication.

Developing your attending and listening skills

The term attending refers to a counsel's ability to pay close attention to the client by limiting distractions and demonstrating that he or she is giving full attention to the client. Attending involves using responsive non-verbal skills such as listening, eye contact, relaxing, and natural hand movements. Responding to the client by nodding affirmatively and using key words such as "yes" and "I see" when appropriate demonstrates attentiveness. Maintaining eye contact shows that the counselor

is engaged with the client (though clients who are annoyed, nervous, or embarrassed might try to avoid it), and will increase the client's confidence and facilitate better communication. The counselor should, however, distinguish between eye contact and staring, which could make the client feel uncomfortable.

Attending to the client is also improved when the physical counseling space is comfortable. A comfortable seating plan, with a culturally appropriate distance between counselor and client, can improve the space. Minimizing distractions, such as noises or disruptions, can also help create a facilitative atmosphere.

The term listening refers to the ability of the counselor to actively listen to the client when he or she is talking. Listening signals concern for the client's problems and allows the counselorr to detect common themes and revealing omissions in the client's remarks. For instance, a client may say, "I'm worried and I want to know my status. I know that my partner has another sexual partner." The common theme here is that a client perceives himself or herself to be at risk of HIV and AIDS because of the partner's behavior. The revealing omission here might be that the client is not using condoms, or that the client fears rejection, violence, or abandonment if he or she were to introduce condoms into the relationship.

While listening, the counselor should pay attention to the following:

- The client's experience–what the client sees as happening or not happening to him or herself;
- The client's behavior–what the client does or does not do;
- The client's feelings–the emotions that arise from experience and behavior;
- The client's problems and worries–client explanations rather than counselor assumptions;
- The counselor's body language–the gestures, facial expressions, intonation, distance, etc., that indicate the counselor is listening and understands what the client is saying; and
- The client's perceptions–the client's point of view when talking about his or her experience, behaviors, and feelings.

To demonstrate listening, the counselor should reflect briefly on what the client has told him or her, paraphrasing the client's words aloud. If the client hears no comments for two to three minutes, he or she might conclude that the counselor has lost interest, disapproves of what was said, or does not understand the client. Counselor can use a formula that expresses the client's principal feeling, such as, "You feel… because…" (e.g., "You feel relieved because you now know your HIV status and are able to change your behavior to remain negative").

Showing immediacy

In the context of HIV counseling, immediacy refers to the ability of a counselor to deal with a situation affecting the way he or she and a client relate to each other at a given moment (e.g., if the client is exhibiting hostility towards the counselor). Immediacy involves the ability to:

- reveal how another person is affecting you;
- explore your own behavior towards the other person;
- share observations about the other person's behavior towards you, or point out discrepancies or distortions; and
- invite the other person to explore the relationship with a view to improving it.

Using an appropriate language level

When communicating with clients, it is important to note that distressed clients often remember little of what they are told. Among the most common reasons for lack of recall is a counselor's use of technical or unnecessarily complicated language. Counseling is more effective when the counselor:

- uses simple and culturally appropriate language;
- ensures that clients feel that they are understood and that a common level of communication is used;
- explains important points more than once–the main message first, then specific details, and finally the message summed up and repeated; and
- puts important points in writing, when appropriate, or uses visual diagrams or printed materials, such as pamphlets or brochures, as memory aids that clients can refer to after a session.

Using impersonal statements

In making a general point, impersonal statements (also known as the third-person technique) can be helpful in reflecting clients' unspoken, but nevertheless perceived, feelings. This technique is very useful in acknowledging, reflecting, and normalizing the client's feelings and keeping him or her from being on the defensive. Examples of third-person statements are:

- "People can feel a lot of confusion and guilt when they hear information about HIV."
- "Sometimes when I give HIV test results to clients, they want to talk about what they can do to keep themselves healthy and where they can go for help."
- "People often feel uncomfortable and guilty when you talk to them about their drug use."
- "Some of my clients want to know how they can stay in good health and where they can find help."

Counseling communication skills Body language

- Good eye contact with clients especially when we are talking about sensitive issues.
- Sitting "with" the client, and not behind a desk
- Sitting a culturally appropriate distance from them and facing them
- Sitting in a relaxed but professional way (not too formal, not too casual)
- Not looking at watch, or taking phone calls or doing other distracting things whilst the client is talking

Non-verbal skills – It is important how we say it

- Not responding to the clients in a way that shows our frustration or displeasure e.g. grunts, sighs or groans.
- Not giggling or sounding surprised when a client says something that embarrasses us
- Talking in a calm manner (not too bossy or directive)

Showing we have listened to the client and understood them

Paraphrasing involves restating, in your own words, the essence of what the client has said. The client says, "I feel so helpless. I can't get the housework done, get the children to school on time, or even cook a meal. I can't do the things my wife used to do." Then the counselor says, "You are feeling overwhelmed by having to do things you did not have to do in the past when your wife was alive."

Reflecting emotions is similar to paraphrasing except that the focus is on the emotions expressed by the client e.g. the client says, "I don't know what to do. Before he died I promised my husband that I would take care of his mother for the rest of her life. But I no longer have the energy. I cannot seem to get myself sorted out to do anything. He knew that his mother and I did not get along and that the situation would be miserable. Why did he die and leave me in this mess?' The counselor reflects, "You seem to be feeling very low and helpless right now, but at the same time you seem to be feeling guilty and angry about your promise to your husband."

Consider how we ask questions

Closed questions: Can be answered with only a one word response “Yes or No” e.g. “Do you practice safer sex?“ This could give us misleading information. The client may say yes but what they think is safe sex may be different to what we consider safe.

Leading questions: Tell the client what we would like to hear e.g. “You always use a condom don’t you?” Clients who are asked these types of questions may give you inaccurate answers.

Open questions Start with “how” “what” “where” e.g. “Many clients have trouble using condoms what are some of the problems you have?” These questions allow the client to explain or describe a situation.

Use silence – do not talk too much

Silence is important because it gives the client as it

- time to think about what to say,
- the chance to experience his or her feelings,
- the ability to proceed at his or her own pace,
- time to deal with ambivalence about sharing, and
- freedom to choose whether or not to continue.

Chapter 3

Behavior Change Strategies in HIV Counseling

What does it take to change behavior?

Individuals' lifestyles and behaviors have a major impact on physical and emotional health. Behaviors that affect health include eating, personal hygiene, sexual activity, physical activity, smoking, and drug or alcohol abuse. Because these behaviors are often deeply ingrained, they are not easy to change. Yet unless harmful behaviors are changed, they can result in preventable illness, poor quality of life, and possibly a premature death. Unhealthy behaviors must be unlearned. This is most always a complex process; if the intent is to change behavior, simply providing clients with information is rarely sufficient. Let us look at an example that illustrates this point in box 3.1.

Box 3.1: Information alone rarely leads to behavior change

The client is a doctor who has worked in a large public hospital and has seen the effects of smoking on his patients' health. He is aware of the scientific evidence about the harmful effects of smoking on his health, yet he continues to smoke. He has a chemical dependency on nicotine, he is overworked, and he smokes when he experiences stress. He also indicates that he is in the habit of holding a cigarette when he drinks alcohol at social functions, when he talks on the phone, and when he is writing up his patient records.

The client clearly knows that his behavior is harmful. However, a number of other factors contribute to his smoking habit. He has a physiological dependency on a substance in cigarettes. He has situational behavioral triggers, which have become entrenched behaviors (e.g., phone in one hand and cigarette in the other). He is also stressed and perceives smoking to be stress-reducing. He will not give up smoking until he sees that the benefits of not smoking outweigh the benefits of smoking, unlearns automatic behaviors such as smoking to keep an empty hand occupied while talking on the phone, manages his symptoms of nicotine withdrawal, and finds substitute strategies for coping with stress.

To change behavior, the individual needs to:

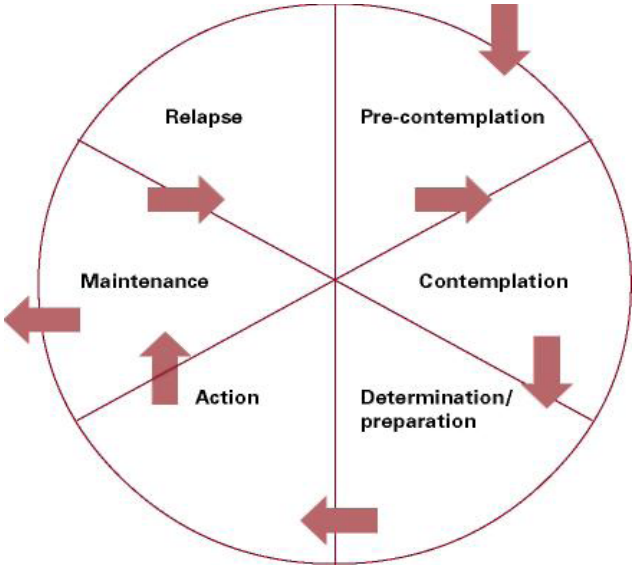
- identify the behavior as harmful;
- understand available alternatives;
- be able to act on that knowledge; and
- receive the support needed to maintain the behavior change.

HIV related behavior change counseling

In STI and HIV counseling, sexual behavior, drug or alcohol use, and poor treatment adherence are probably the most important behaviors to consider in relation to HIV transmission risk. Reducing HIV transmission in the community and helping HIV-positive clients stay healthy are essential components of the counselor's job is to support clients in recognizing which behaviors are a transmission risk (see chapter 1: How is HIV transmitted?) and to assist clients in choosing and sustaining safe and healthy behavioral patterns. The counselor must explain the advantages and disadvantages of behaviors such as the use of alcohol, tobacco, and other drugs; sexual activity; and eating habits. The counselor facilitates change by:

- Helping the client to anticipate challenges to behavior change;
- Working collaboratively with clients to develop effective strategies to meet the anticipated challenges; and
- Reinforcing the achievements.

Stages of Change



Source: Prochaska JO, DiClemente CC, Norcross JC. In search of how people change. Am Psychol 1992;47:1102-4 and Miller WR, Rollnick S. Motivational interviewing: preparing people to change addictive behavior. New York: Guiford, 1991:191-202.

Supporting behavior change is a complex interaction between the counselor and client that requires a great deal of insight into human nature and motivation. It requires the counselor to help clients recognize behaviors that are harmful to their health and to acknowledge the difficulties that changing behaviors will present.

No single strategy for behavior change can address all harmful behaviors. The three strategies presented here–risk elimination, risk reduction, and harm reduction–can be thought of as tools for assessing clients and their concerns. In this chapter we will primarily address behavioral strategies for reducing STI and HIV transmission. Strategies for managing treatment adherence will be addressed in chapter 8.

How do I get a client to want to change his or her behavior?

Decisions to change certain behaviors, for example, by abstaining from drug or alcohol use or starting to use condoms, are difficult to make. Clients don't often state openly that they would like to change these behaviors. Often they are in a state of ambivalence and fluctuating motivation before deciding to make a change. If a client is either not ready or ambivalent about change, advice in the form of demands or attempts to use heavy persuasion may put him or her on the defensive and increase the resistance to change. The concept of stages of change developed by Prochaska and Di-Clemente1 (see figure above) shows that, for most persons, a change in behavior occurs gradually, with the patient moving from being uninterested, unaware, or unwilling to make a change (pre-contemplation) to considering a change (contemplation) and deciding and preparing to make a change. Genuine, determined action is then taken and, over time, attempts to maintain the new behavior occur. Relapses are perceived as almost inevitable and become part of the process of working towards sustained change.

Motivational interviewing is a non-confrontational approach to counseling. Studies have found it to be highly effective with clients in the pre-contemplation or contemplation stages of behavior change related to drug, alcohol, or tobacco use, as well as safer sex practices. The goal is to explore the clients' ambivalence towards change and to encourage them to express their concerns and individual reasons for change. The key concept in motivational interviewing is resolving ambivalence about the need for change. First let us take a look at the summary table of interventions appropriate to each stage of change in relation to drug use. Then we will look at motivational interviewing strategies in more detail.

Prochaska JO, DiClemente CC, Norcross JC. In search of how people change. Am Psychol 1992;47:1102-4, and Miller WR, Rollnick S. Motivational interviewing: preparing people to change addictive behavior. New York: Guiford, 1991:191-202.

Behavior change counseling strategies for the states of change, as applied to drug users

Stage of change	Behavior-change counseling strategies
Pre-contemplation The client does not perceive that he or she has a problem or that it is an immediate problem.	• Find out whether the client is experiencing life problems such as lack of money or a relationship breakdown. • Find out the health impact of the behavior from the client's perspective. • Ask the client how much drug use is affecting or contributing to his or her problems. • Provide personalized information about general health problems resulting from continued drug use. • Provide personalized information about the client's HIV status and the risk taking associated with drug use (lack of safer sex practices, unsafe injecting, etc.). For example: "You have had several HIV tests because you have not been able to inject safely or use a condom. Each time you have been anxious about the result. Do you want to continue going through this?" Or, if the client is already HIV-positive: "Now that your doctor has recommended that you start treatment." In both cases you should provide the client with information. (provide information)
Contemplation The client is seriously considering giving up drugs in the next six months.	• Acknowledge the client's ambivalence. • Ask the client what he or she (not the counselor) sees as the benefits and problems of continued drug use, and the benefits of and barriers to stopping. • Help the client to see potential solutions to the various barriers raised (loneliness, common practice among friends, withdrawal symptoms, etc.). • Help identify potential resources (e.g., detoxification facility services, recovery groups, treatment buddies).
Preparation The client intends to quit within the next month; has tried to quit in the past year or has made behavioral changes (e.g., tries to use clean injecting equipment or reduce use).	• Establish an action start date. • Help client develop awareness of practice of keeping a habit diary (if illiterate, interview and do the recording, or use low-literacy self-recording), noting issues such as when he or she uses drugs, who with, how much, etc. If the client is illiterate, interview and do the recording. • Establish degree of dependency. Use ICD 10 or other standard diagnostic criteria. • Interview the client about past attempts to stop using drugs. Determine the process with the client, including detox, gradual withdrawal, oral substitution therapy. • Interview the client to establish why the client uses drugs (social use, depression, strategy for coping with sex work, etc.).

Action phase	• Help the client develop a plan of action. • Facilitate referrals or preliminary visits to drug treatment services. • Support skills rehearsal, e.g., informing partner of wish to enter a methadone program.
Maintenance phase The client is free of drugs or in recovery program for six months.	• Anticipate and normalize relapse. • Review triggers for relapse and coping strategies. • Support progress and monitor health and highlight positive consequences of changes (e.g., increased condom use during sex; less STIs; improved appearance; improved relationships with partners, families; new friends; better financial situation).
Termination The client is 100% confident in all trigger situations.	• Congratulate the client and again remind him or her that you are available for follow-up.

Getting started with motivational interviewing

Counselor should select the strategy for a given session depending on the patient's readiness for change. More than one strategy can be used in a session. The counselor works through the list of strategies in box 3.2 as the client becomes more ready to change.

Box 3.2: Strategies used in motivational interviewing

Opening strategy: lifestyle, stresses, transmission risk behavior, and substance use

- A "typical day" /Session review
- The good things and the less good things about change
- Information provision
- The future and the present
- Concerns about change
- Help with decision making

Example: Your client uses injecting drugs and shares injecting equipment and does not use condoms for sex

- The skills you will primarily use here are reflective listening and open questioning. Your job is simply to develop an understanding of the client's feelings without criticism, judgement, or blame. Use an opening strategy such as talking about the client's life and the current stresses he or she is facing: " How is your life at the moment?"; "What's happening in your life right now?" You do this even if the client has come in about a specific health problem like an STI or for an HIV test.
- At this point the client may discuss the positive aspects of using drugs and say that he or she is in control of the use of drugs.
- The counselor could then say, "How do you see your drug use affecting your health?", or talk about whatever issues the client raises (e.g., relationships, financial situation). The main point is to build rapport with the client and assess his or her readiness for change.
- Avoid using terms such as "problems" or "concerns" and do not assume that a given issue or circumstance is a "problem" for the client. Do not confront resistance or denial at this stage and simply say something like,"I can see how this does not feel like a problem for you right now."
- The counselor then begins to focus on the events of the day and how the client feels about them. Questioning shifts to inquiries such as, "Tell me about a typical day in your life… How about

last Friday?" "After you got up in the morning, how long was it before you had your first hit that day?";"How did you feel after it?" Explore a typical day in the life of the client. The counselor mainly asks simple, open-ended questions. The aim here is to raise the client's awareness of the relationship between drug use and what is happening in his or her life. This strategy is particularly useful for pre-contemplators.

- The next step, either in the same session or in a later session, is to ask the client about the good things and the things that are not so good about drug use and then to respond with a reflective statement that links the two responses. For example: "So your use of heroin helps you relax when you are having sex with clients." Or:"On the other hand, you say that sometimes clients hurt you, don't pay you, or have sex with you without using condoms because you are relaxed."
- Providing information about drugs is routine in health services, especially with people at risk of or living with HIV. The important issue here is the way the information is exchanged. The information should be impersonal and neutral. For example, you may want to say something like: "Using drugs can cause liver problems and make it difficult for people to protect themselves from sexually transmitted infections. It can even make it difficult for people with HIV to use and benefit from the new HIV treatments." Or: "Sharing injecting equipment and engaging in unprotected sex as well as missing some doses of medication can make people resistant to treatment." This should be followed up with a simple open question such as:"How do you feel, or what do you think about that information?"
- The strategy called Future then Present, about the future and the present, can be used with clients who are becoming concerned about their behavior. The counselor can focus on the present behavior and how the client would like to behave in the future, thus indicating a discrepancy. This can provide the motivation to change behavior. Ask: "How would you like things to be in the future?" Once future goals have been elicited, a counselor can return to talking about the present, asking for example: "What's stopping you right now from having or doing those things?" Listen, and then ask: "How is your drug use affecting you right now?" This will lead to a direct exploration of the concerns and problems that drug use is causing the client, and to a discussion of behavior change.

Motivational interview strategies can be used effectively when integrated with the stages-of-change model. Knowing which stage of change the patient is in gives you a place to start when deciding which strategy to employ. Let us take a look at strategies for our injecting-drug-using client, as presented previously in the summary table on page 26.

Strategies for the action and maintenance phases

Using a simple structured problem-solving approach

Once the client decides to make a change, the counselor's role is to facilitate behavior by collaboratively engaging the client in structured problem solving. This approach can be summarized as:

- describing the problem that results in HIV transmission;
- brainstorming about the options for behavior change–selecting the risk elimination, risk reduction, or harm reduction approach (discussed on page 29);
- critically evaluating the options–asking the client to consider the benefits and potential problems associated with each strategy; and
- developing an action plan with opportunities for a "provisional try".

As a counselor you must then offer support in developing the skills needed to fulfill the action plan. This may include, for example, role-plays that involve condom negotiation, practice in using condoms, or training in cleaning injecting equipment.

Reviewing options

The client reviews the advantages and disadvantages of different ways of altering behavior. The counselor asks the client to brainstorm about the advantages and disadvantages of different options. In our example of risk elimination for a drug user, this may include abstinence, brainstorming about the gradual reduction in drug use, or considering oral substitution therapy. In the case of sexual transmission risk reduction, options might include abstaining from sex, using condoms for sexual partners other than a tested regular partner, and choosing sexual activities with a lower transmission risk. Three broad strategies that relate specifically to choices for transmission risk reduction are presented later in this chapter.

Risk elimination: ”Abstaining from sex and refraining from injecting drugs is best”

Risk elimination relies on abstinence to eliminate the risk of HIV infection. According to this strategy, the client should abstain from sex and refrain from injecting drugs. The risk of infection is eliminated because the behaviors that lead to it are eliminated. Examples of prevention education messages based on risk elimination are the sexual abstinence and just say no to drugs campaigns. Both campaigns have failed to reduce HIV or change the behavior that leads to HIV infection.

While adherence to risk elimination guarantees 100% safety from infection attributable to those behaviors, it is often the least-useful behavior-change strategy because most people find it extremely difficult to do away with risky activities such as drug injection or sex.so options to minimize the risk to be provided to minimize the risk of getting HIV.

Risk reduction: ”Use a condom and do not share injecting equipment”

Realizing that many people cannot stick to the risk elimination strategy, some counselor and educators opt for risk reduction, a strategy that realistically acknowledges that some individuals will continue to engage in risky behaviors. Assuming that abstinence is not a realistic alternative, the risk reduction strategy advises individuals to engage in ”safer” behaviors–using condoms during sex or when engaging in low-risk sexual activities, and not sharing needles when injecting drugs.

The risk reduction strategy, however, cannot offer a 100% guarantee that a person will remain uninfected. For example, if a condom breaks during intercourse, the client will be at risk.so proper skills to be provided to the clients how to use condom correctly to minimize breakage of condom.

Harm reduction: ”Follow a step-by-step process of change”

The harm reduction strategy recognizes that risky behaviors not only occur but also have meaning. This strategy assumes that risk is a part of life and ranks an individual’s risk of HIV infection among other life issues, such as illness, unemployment, and drug use. The harm reduction strategy rejects the all-or-nothing approach to behavior change. Instead it conceives of change as incremental and taking place over time. Any positive change brings the individual one step closer to healthy behavior. The counselor works with the client to identify risky behaviors, understand the reasons why he or she may continue to engage in them, and identify what the client can do to move towards healthier behaviors. Needle- syringe exchange programs, for example, acknowledge that some clients engage in risky behavior (injecting drugs). Eliminating the behavior that puts them at risk might not be an immediate goal of this strategy, but for some it can be a long-term objective.

These three strategies, and many others, are available to HIV counselor and educators. Elements of different strategies may be appropriate at different times for the same client. Most importantly, HIV educators and counselor must be familiar with these strategies and know how best to use them–not as absolutes but as tools for interacting with clients. Educators and counselor should also keep in mind that they can adapt each strategy to their own style and culture.

Developing an action plan with a timeline

The action plan should be a clear list of tasks associated with the behavior change; each task should include a date (e.g., opioid maintenance centers, visit potential detoxification centers, or buy condoms). The strategy should be built up in steps so that small changes can be rewarded or acknowledged. For example, this may involve setting a goal of asking one person to use a condom in week 2 or to enter a detoxification program and join an anonymous anti-narcotic support group.

Making a provisional try (an initial attempt at behavior change)

The provisional try takes place when a client leaves the counseling session and attempts a step towards changing behavior. Though provisional tries may not always be successful, the minimal attempt at behavior change can be considered a success and must be supported by counselor. Counseling strategies during the provisional-try stage include:

- reinterpreting the concept of ”failure” (”This was an experiment and we just wanted to see what happened so we could plan for problems”);
- asking ”why” in a positive way (”Let’s look at what happened so we can carefully plan”); and
- providing closure (”Different strategies work differently for different people; we can try something else”).

Preventing a relapse

Relapse prevention strategies are an important part of behavior-change interventions. Clients should not feel they have failed. Planning for a relapse makes them aware that a relapse is likely to occur as it is a natural part of the behavior-change process, and that it does not mean failure or even a setback.

Relapse prevention strategies

- Identify high-risk situations (triggers)
- Develop trigger management skills
- Rehearse trigger management skills
- Engage in structured problem solving
- Get back on track after a relapse

Most relapse prevention plans call attention to possible triggers that can bring forth the old behavior (e.g., send a drug or alcohol abuser back to his or her drug of choice, or let somebody share injecting equipment or not use a condom during sex). The client is encouraged to come up with a list of potential triggers that need to be avoided or addressed once they occur. The counselor can ask the client to monitor his or her drug use, for instance, or contexts where it may be harder to use condoms. If the client cannot keep a record, then the counselor can ask questions that will elicit this information.

The principles and strategies outlined in this chapter can be applied to a range of target behaviors. Behavior-change counseling may not always be about changing adverse behaviors; it can also be about developing new behaviors–improving diet or developing an exercise habit.

Chapter 4

Counseling in association with the HIV Test

Section 1: approaches to HIV testing and counseling

There are different approaches to testing individuals for HIV. According to National Guideline HIV testing and counseling should be voluntary and always undertaken with informed consent, counseling, and confidentiality, correct testing and connection to treatment care and support (5 Cs). Different approaches are in use in Nepal

Client-initiated HIV testing and counseling

In this model, sometimes referred to as voluntary counseling and testing (VCT), individuals actively seek HIV testing and counseling at a facility that offers these services, perhaps as a result of provider referral. Client-initiated HIV testing and counseling usually emphasizes individual risk assessment and management by counselor, addressing issues such as the desirability and implications of taking an HIV test and the development of individual risk reduction strategies. Client-initiated HIV testing and counseling is conducted in a wide variety of settings, in health facilities and stand-alone facilities outside health institutions, special health facilities for the risk groups, integrated with STI and care services for PLHIV, through mobile outreach services, in community-based settings, and even in people's homes.

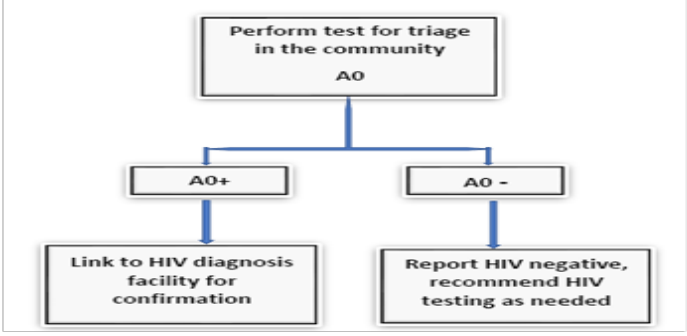
Provider-initiated HIV testing and counseling

This refers to HIV testing and counseling that is recommended by health-care providers to persons attending health-care facilities. If someone were to present to health facilities with symptoms or signs of illness that could be attributed to HIV, for instance, it is a basic responsibility of heath-care providers to recommend HIV testing and counseling (also often referred to as diagnostic testing) .

Provider-initiated HIV testing and counseling is also done to identify unrecognized or unsuspected HIV infection in persons attending health facilities that provide services to populations engaged in behaviors that may put them at risk of HIV. Thus, HIV testing and counseling would be recommended to tuberculosis patients and those suspected of having TB, given the frequency of this disease as an OI. Even if they do not have obvious HIV-related symptoms or signs, such patients may nevertheless have HIV. Knowing their HIV status may induce them to seek specific preventive or therapeutic services. Similarly STI patients were also be tested for HIV .All ANC attenders are also tested for HIV with this PITC approaches.

Community led-testing

Community-led testing is recommended as part of CBT and 'test for triage' strategy in which KPs are offered HIV testing services by trained peer as lay providers. It can be performed in both facility and community settings. Lay providers can conduct screening tests either with blood or oral -fluid- based.



Procedure:

- Lay providers conduct a single HIV rapid diagnostic test (RDT) referred as A0 (Assay 0) which can be blood-based or oral-fluid based testing kits.
- Clients with reactive test results (A0+) should be referred and accompanied to health facilities where confirmatory testing is performed by trained laboratory personnel ording to the National algorithm. Confirmatory tests can be conducted in community following National algorithm.
- Non-reactive test results (A0-) should be recommend for re-testing based on risk factor identified and referred to prevention services.
- Recording and reporting of such screening will be done as per HMIS guidelines. All community testing services (CBT/CLT) sites should participate in quality assurance mechanism conducted by the National Public Health Laboratory (NPHL).

HIV self-Testing

HIV self-testing HIV ST is a test process where an individual collects his or her specimen, performs a test, interprets the results in a private setting either alone or with someone he or she trusts. HIVST is a screening test only. A confirmatory test should follow reactive HIVST to make the confirmed diagnosis.

HIV self-testing can be done following oral fluid-based approach and blood-based approach. Blood -based self testing is not introduced in Nepal. We discussed here oral fluid-based testing approach only.

Approaches for providing HIV self-test

HIVST can be delivered through two approaches i.e. supervised and unsupervised. Supervised HIVST includes individuals who are performing HIVST receive in-person assistance from a trained provider or peer before or during HIVST with instructions on how to perform a self-test and how to interpret the self-test result.

Unsupervised HIVST includes individual obtaining a kit for HIVST and performing the HIVST himself/ herself following the instructions in the insert. The person doing self-test is requested to report the result within a specific time frame to the person providing test kits.Specimen and test kit Specimen used for HIV self-testing is oral fluid (gum secretion) and a kit used in Nepal is OraQuick® Rapid HIV Self-Test, manufactured in Thailand for OraSure Technologies is used. It is single use qualitative immunoassay which detects antibodies to HIV-1 and HIV-2. According to OraSure Technologies, Inc., the test kit has 100 percent sensitivity and 99.1 percent specificity compared with a fourth-generation laboratory test. The test kits had certain limitations. The test may show a false report if the person is taking antiretroviral (ARV) drugs, infected with hepatitis B virus (HBV) and hepatitis C virus (HCV) or human T- lymphocytic virus I/II (HTLV (I/II). Oral bleeding may result in an invalid result and the test kit may not detect an HIV infection that has occurred within the last three months.

Pre-test information should include:

1. HIVST is a screening test of HIV. It uses secretion between lips and gums. No need to prick or draw blood. Though we are testing HIV-antibody from oral fluid, the amount of HIV found in oral fluid is so small, that it is not adequate to transmit HIV. HIV is not transmitted from oral fluid or saliva
2. It does not give the confirmed result, those having reactive test result needs retesting in facility for confirmation

3. Client cannot eat or drink at least 15 minutes before using HIVST kits and/or can not brush teeth or use mouth wash 30 minutes before using HIVST
4. HIVST is not recommended to those people who are using ARV treatment. Shows the kit insert or electronic flip chart and explains step by step procedures for using HIVST
5. Results given by test kits are HIV reactive and HIV non-reactive. Explains that there should be two lines in result window of test kit- near “C” and “T”, to consider result reactive. Only one line near “C” indicates nonreactive result
6. HIV non-reactive means that the client is found not infected with HIV using this test kit
7. Client with nonreactive result should always use condom and lubricant during sexual contact or use only new sterilized syringes for injection
8. Test kit if taken for un-supervised test, can only be stored in cool and dry area, cannot be stored in freezer compartment of refrigerator, test should be performed in area with temperature 15-37 degree Celsius, that is warm temperature
9. Used test kit is not infectious, cannot transmit HIV. However, it needs to dispose in safe place and privately. They can choose self-testing approach- Supervised or unsupervised
10. There are two approaches for HIV self-testing- supervised and un-supervised. The client has freedom to choose the approach suitable for him for HIV self-testing. Provide assistance according to the choice of client

Post-test should include

For clients with nonreactive results:

1. Explain that test kit showed only one line near ‘C’ in result window of the test kit, it shows the test result is non- reactive. Nonreactive result means the client is not found infected with HIV during this test.
2. Ask client to test for HIV at least once in six months or more frequently if risk exists.
3. Encourage client to remain HIV negative by using condoms and lube during sexual contact or using new syringes for injection or taking tested blood (if needed) only.

For clients with reactive result:

1. Explain that test kit showed two lines-one near ‘C’ and one near ‘T’ in result window of the test kit, it shows the test result is reactive. Reactive result means the client is suspected to have HIV infection during this test.
2. Explain that the client needs to test again to confirm HIV in a health facility following national algorithm.
3. Explain that if confirmatory test shows HIV positive status, you will help him/her for enrollment in HIV treatment. HIV treatment is needed to control HIV in body and requires lifelong use. Treatment of HIV is available free of charge from government or government supported facilities.

All persons identified as HIV test reactive (A 0+) using HIVST or by test for triage should be re-tested using national testing algorithm to confirm HIV status.

Index testing

Index testing is a focused HIV testing approach in which providers work with individuals living with HIV (index clients) to elicit their sexual or injecting partners, their biological children, or biological parents (if a child is the index client) for HIV testing and . With the assistance of a trained provider, PLHIV can choose from the following options for offering testing to named contacts: client referral, contract referral, provider referral, and dual referral modalities. Violence screening and referral is

an essential component of index testing. Index testing is an approach with highest HIV case finding yield. Case finding is highest if index testing is offered to following group of people:

1. Partners of index clients apparently in acute infection and/or recently identified
2. Partners of clients with unsuppressed viral load result
3. Partners of clients with no treatment
4. pregnant or breastfeeding partners
5. Recent unprotected sex with partner
6. Needle/syringe sharing partners
7. Large number of sex partners
8. Large age difference between partners (particularly for adolescent girls)

Index Testing Services are NOT a one-time event but should be offered in continuous manner.

Need for index testing

Partners and children of HIV positive are at greater risk of getting HIV. Early identification of HIV and initiating treatment as early possible is key for viral load control leading to healthy life. Index testing is one of the highest yield testing approach.

Explain and conduct intimate partner violence screening

It is not always easy to disclose HUV status to partners of HIV positive. Similarly offering HIV testing may also pose risk to index client. Conducting screening of intimate partner violence (IPV) minimizes risk of IPV to index client. Following simple questions are used for screening of IPV, 'Yes" answer to any of the questions below, is adequate to stop further partner notification.

a) Has your partner ever hit, kicked, slapped, or otherwise hurt you?
b) Has your partner ever threatened you for physical violence?
c) Has your partner ever forced you to do something sexually that make you uncomfortable?

How notification and referral for testing done?

Client referral: The provider elicits sexual/injecting partners, biological children, or biological parents (if child is index case) from the index client. The provider encourages the client to disclose his/her status to sexual and/or drug injecting partners by themselves, and to also suggest HIV testing to the partners. The provider does not have any contact with the referrals until the point at which they come in for testing.

Provider referral: With the consent of the index client, a trained provider confidentially contacts the person's referrals directly and offers the referrals voluntary HIV testing.

Contract referral: The index client enters into a contract with a trained provider and agrees to disclose his/her status and/or refer partners to HIV testing services (HTS) within a specific time period. If the partners of the HIV-positive individual do not access services or fail to contact the health provider within that period, then the provider will contact the partners directly.

Dual referral: The provider offers support and accompaniment to index clients to disclose their HIV status and offer testing services to the partners.

Referral can be made without disclosing HIV status of the partner. Such referral is termed as anonymous referral.

Risk network referral (RNR)

- Extends beyond index testing. Providers offer PLHIV additional, self-guided options to informally extend links to HIV testing and other services to a broader set of social- and risk-network members who have an elevated risk of HIV infection. This broader set of social and risk network members can include other friends and acquaintances who live and work within the same area or have similar risk behaviors.
- Is conducted through online and coupon-based referrals
- Does not require PLHIV to name — or even know the names of — these contacts to make referrals. They can make confidential or anonymous referrals.

Examples include:

- Entering phone numbers on a secure website of individuals whom they would like to receive a testing promotion
- Sending a mobile phone message with an embedded link that allows recipients to access a website where they can make an appointment for testing or even order an HIV self-test
- Is often offered at the same time as index testing. Some index clients might accept RNR for some of their contacts and index testing for others, or clients may decline both index testing and RNR.

Table 4.1 Index testing Vs RNR

	Index testing	RNR
Primary purpose	Case-finding of referrals	Case-finding of referrals
Target group	Sexual and injecting partners, biological children, biological parents (if child is index client)	Broader set of social- and risk-network members
Includes coupon-based referrals?	No	May include coupon-based referrals
Employs peer incentives?	No	No
When is it offered?	Outreach, testing, diagnosis, care registration, treatment initiation, community and clinical support, viral load testing	Outreach, testing, diagnosis, care registration, treatment initiation, community and clinical support, viral load testing
Disclosure	HIV serostatus of index client is known by program staff who are providing services to that client	HIV serostatus of index client is known by program staff who are providing services to that client

Task for counselor while offering index testing:

1. Offer index testing to all HIV positive clients coming in contact with service site – identified HIV positive clinics, followed up in the community by PN or any HIV positive as mentioned above
2. Offer HIV test and STI screening to married and cohabiting couples, premarital couple, partners of MSM and TG people and other sex partners.
3. Introduce basic partner notification services concepts and benefits at pre-test information or
4. Receive the written consent from the index client to test his or her partner and provide referral card to the client for all cases.
5. Conduct screening of intimate partner violence using index testing form. Hold partner notification if there are risk of intimate partner violence.

6. Discuss about the disclosure of the status and ask the client to take initiatives.
7. Offer disclosure .
8. Prepare a list of the partners and children at risk as well as people at network of HIV positive who are at risk of getting HIV with their contact information, after receiving consent from client.
9. Discuss with HIV positive the possible ways of notification and referral. Mention preferred way in the list and also if applicable contract date.
10. Follow up as agreed with index client and arrange for HIV testing.
11. Discuss preferred place for HIV testing, whether to test in static or mobile clinic, mobilizing CBS or PN for CLT followed by confirmatory test in the clinic, if the test result is reactive or confirmatory testing by laboratory assistant during the field visit.
12. Provide accompanied referral to ART center for ART to all identified HIV positive from index testing
13. Fill index testing forms for all partners
14. review the client's understanding of HIV/AIDS and STI
15. help the client understand why the test is needed;
16. explain the test and clarify its meaning;
17. psychologically prepare the client for a potential HIV-positive result;
18. explain the limitations of the test and the various results that can be obtained; and
19. Obtain informed consent.

Section 2: pre-HIV test or group information

Where possible, pretest information in groups or individuals or couples is desirable. Such counseling is intended to:

To meet these objectives counselors need to strike a balance between collecting and offering information by listening to and meeting the client's own needs.

1. Introduce the service

The first step in pretest counseling/ group information is to establish a relationship with the client. This phase involves clearly explaining your role. The client should be told how much time is available for counseling. The reasons for note-taking and filling forms should also be explained. This explanation should be accompanied by a brief overview of how you and the organization you are working for will protect their confidentiality.

2. Clarify information on HIV and STI transmission

It is important for you to ascertain the client's level of knowledge about HIV,AIDS and testing. Identification of misconceptions and misunderstandings to be done , so that they can be corrected.

Briefly discuss the ways HIV can be transmitted and how STIs can facilitate HIV transmission. Also discuss how HIV is not transmitted.

Briefly outline how having HIV test can give PLHIV to treatment, and how the knowledge of their infection and its treatment can allow them to make decisions to improve their health and protect their partners and children. At this point, the client should also be told about the implications of the window period and HIV testing. Let us look at an example in box .

Sample When HIV infects a person's body, the body realizes that HIV is a virus that should not be there. The body's immune system will then begin to develop something called antibodies to try to fight against HI and protect the person. The test used to check for HIV looks for these antibody in blood. It is called an antibody test. Currently nationally supplied tests kitcandiagnose HIV after 21 days of infection. Explanation of the window period.

3 Demonstrate condom use and discuss safe injection

Clients should be able to demonstrate that they can properly apply a condom to a dildo. You could first demonstrate this and then ask the client to try to do the same. Safe injecting skills should be reviewed together with a discussion of how to gain access to safe injecting equipment and how to avoid sharing injecting equipment or drawing from a common vial or ampule. If the injecting drug users are using opioid substances counseling to be provided on opioid substitution therapy.

4. Explore psychological coping resources

It is important to screen for any current or pre-existing psychological disorders such as depression, anxiety, or psychosis, as well as patterns of drug or alcohol use that may adversely affect the client's ability to reduce transmission risk and to cope with a positive HIV test result (see box 4.3). While this screening could be done at the time you provide the result, clients who are in crisis are often unable to provide the necessary information adequately. Chapter 6, section 2, offers suggestions on how you can assess and support clients with psychological disorders.

HIV testing and counseling for drug- and alcohol affected clients

Before starting HTC you must assess and consider whether a client's understanding of the process and procedures is likely to be impaired by drugs or alcohol, making it difficult for the client to listen, provide information, and cope with emotions that are typically elicited by the HIV testing and counseling process. Assess the client's ability to comprehend information by:

- ensuring that the client is oriented to time and place; and
- asking the client questions and checking to see that he or she answers coherently.
- If you think that the client's ability to participate fully in counseling and informed consent to testing may be compromised, it is suggested that you:
- discuss this with the client in a supportive way;acknowledge that you understand that this is a stressful situation; and
- assert that you cannot proceed while the client is heavily under the influence of drugs or alcohol.

In pretest counseling you may need to ask the client to wait in a waiting room or to come back later that day when he or she is better able to understand the process of HIV testing and counseling. During pretest counseling clients should be informed that a result can be provided only to clients who fully comprehend what they are told. This may mean that they have to limit the intake of drugs and alcohol before post-test counseling.

5. Assess anticipated support from partners and family

Again, while this information can be collected at the time the results are given, it is better to have a prior understanding of the client's potential support. Clients with significant risks may wish to discuss

with their partner or family the fact that they are having a test and to include them in the pre- and post-test counseling. The client must be consulted and consent obtained before the partner or family is involved in test result provision.

6. Discuss test procedure and obtain consent

The client should be given basic information on how blood will be collected and results provided. He or she should be reminded of the limitations posed by the window period and consent to the test should be obtained. Depending on your local health policy the consent can be given in writing or orally. If written consent is not required you should simply note on the counseling form that the client gave oral consent.

Clients should be told about the measures taken during blood collection and laboratory testing to ensure that the result they receive is accurate. Sometimes clients refuse to accept a positive test result, convinced that, because of some laboratory mix-up, it really belongs to somebody else.

Table 4.2 Elements of pretest HIV counseling for groups and individuals

Group	Individual
• Confidentiality and privacy; • Basic information about HIV; • Basic information about HIV transmission and HIV risk reduction; • Demonstration and discussion of condom use; • Benefits of testing, and potential issues; • Testing and result provision procedures; • General information about reproductive health.	• Personal risk assessment and feedback of individual risk; • Informed consent.

How is window-period exposure assessed during group counseling sessions?

The window-period exposure must be assessed when the test results are provided. All results must be given individually, in a post-test counseling session, window period should be assessed specially for those who are provided HIV negative results.

Pre-HIV test information for couples

Such counseling should be encouraged, not only for those planning to get married but also for those already in a relationship who wish to make informed decisions about having children and planning a family, and generally for those who want to work on their relationship and plan their future. However, couples should not be coerced into being counselled together. It is always wise to have separate individual risk assessments to reduce the risk that transmission risks will not be acknowledged, as they might not be in a joint counseling session. Confidentiality is important and couples should be told about what is covered and what the limits are. These points are discussed further in chapter 9.

You should listen attentively to the couple as they explain why they have come to be tested. Each partner should be given equal opportunity to talk and ask questions, and the counselor should be non-judgemental and respectful in responding to the couple. Couples should be given relevant and accurate facts about HIV and AIDS to help them make informed decisions.

They should be supported in exploring the likely implications of their test results for their relationship, marriage, sex life, family planning, and child-bearing plans. Each partner should be given the

opportunity for individual counseling, as some may find it threatening to explore their sexually risky behavior in the presence of their partner. Together, couples should also look into the practicality of any changes in their sexual practice such as abstinence, condom use, or non-penetrative sex. The majority of studies on couple counseling among discordant couples (only one of the partners is infected) report success in changing behavior to avoid infecting HIV-negative partners.

Section 3: post-HIV test counseling

The good rapport with the client is required to develop by the counselor the client. However, under PITC you may often find yourself required to provide a result to clients whose testing process was initiated by a doctor. Additionally, the client may have only group pretest information or may have been told that the HIV test was to be done by a doctor.

In other circumstances you may encounter a client who is unaware that he or she has been tested. You will need to first introduce yourself and explain your role and try to establish rapport before providing the test result. When another health provider has initiated the testing process it is important that you establish what information has already been provided by that service provider. Ideally you should clarify directly with the initial provider what information was given to the client, and more importantly whether the client was informed that an HIV test was to be administered. Unfortunately, counselor are sometimes asked to provide an HIV-positive result to a client who was not told he or she was to be tested, and therefore did not give consent. Giving results in such a situation will be discussed below in the section on providing results to an HIV-positive client or patient.

Key procedural considerations for post-HIV test counseling

- Cross-check all results against client files. This should be done before the counselor meets with the client, to ensure that the correct result is provided.
- Provide results to the client in person. Providing results to the client in person ensure not only that the appropriate person receives the results and confidentiality is protected but also that the client adequately understands the results and receives sufficient support.
- Be aware of the manner in which you call clients from the waiting area. A counselor may unwittingly convey results to clients and others in the waiting area through verbal and non-verbal behavior when calling clients in to receive their results.
- Provide written test results. National VCT Guidelines allows providing written test result to the client. All results provided under these circumstances should contain a disclaimer clearly informing the reader that the results may not accurately reflect the status of the individual as he or she may have had exposure within the window period or after taking the test. A client who wishes to share the result with a partner should be advised to make an appointment together with the partner, who may then be shown the result in the client's presence.

Informing clients of HIV test results

CT canters should ensure that clients tested for HIV infection receive their test results on the same day to reduce loss to follow up. Laboratory technician provides HIV test result with clients code number to the counselor who in turn gives the written HIV test report to the client during post test counseling. Strict confidentiality of the HIV test result must be maintained.

A client who wishes to share the result with a partner should be advised to make an appointment together with the partner, who may then be shown the result in the client's presence.

Reading post-HIV test results

- For a negative result, say, ”Your test result was negative. That means we did not detect any antibodies for HIV.” in this result. While providing negative result, assessment of last exposure, ongoing risk behavior and reduction of risk behaviors by maintaining harm reduction and or condom use needs to be counseled. And if the risk of exposure lies within the window period-then for retesting and date to be provided so that testing can be done without delay.
- For a positive test result, say, ”Your test result was positive. That means you are infected with HIV.”
- Before proceeding, it is important to make sure that the client has understood the test result and absorbed the information mentally and emotionally.

Detailed steps to follow when providing HIV-negative results

- Review the clients understanding about HIV . Check all laboratory results and client codes to reduce the possibility of providing incorrect results or information.
- Begin the post-test session by asking how the client has been feeling since he or she had the blood sample drawn. Congratulate the client for returning or waiting for the results.
- When the client is ready, give the test results in a neutral tone of voice and wait for the client to respond before proceeding. Say, ”Your test result was negative. That means we did not detect any antibodies for HIV.” Before proceeding, it is important to make sure the client has understood the test result and absorbed the information mentally and emotionally. Sometimes clients misunderstand ”negative” to mean that the test is flawed or that the news is bad and they have HIV.
- Check for possible exposure in the window period, one that was undisclosed in pretest counseling or that may have occurred since then (if same-day results are not provided). Though clients may be HIV-negative, according to an antibody test result, they may still be HIV-infected and in the window period and may therefore be highly infectious. A client who has had an exposure risk that necessitates a retest should be provided with a date for retesting (based on national HIV testing guidelines). Clearly communicate to the client that he or she may be infected and able to pass on HIV and therefore needs to have a follow-up test.

Reinforce information on HIV transmission prevention strategies and personal risk reduction plan. Some clients who have engaged in high-risk behavior without becoming infected may think they are immune and may therefore see no need for any behavior change. Review and explore any safe-sex constraints and infant-feeding issues (if the client is breast-feeding), or discuss the impact of drug or alcohol use on commitments to reduce future HIV and STI transmission risk. Review information contained in the Behavior-Change Counseling section (chapter 3) of this handbook.

Clients who disbelieve their negative test results

Many clients find it difficult to believe an HIV test is actually negative, especially if they have engaged in high-risk behavior or in activities that they feel are wrong. A negative test result cannot reduce their deep-seated anxiety and belief that they are actually infected with HIV. They may therefore become frequent testers, presenting at health services and discussing the presence of symptoms they believe to be HIV-related.

It is important to clarify whether the client has an undisclosed HIV risk or is continuing to engage in risky behavior. Sometimes this is why people find it hard to accept an HIV-negative result. If reassurance does not reduce anxiety and the client repeatedly asks to be retested, consider referring

the client to a mental health specialist for follow-up treatment and shift the focus of counseling from a discussion of HIV and its symptoms to a discussion of the impact of worry on the client's life.

Detailed steps to follow when providing HIV-positive results

- Begin the post-test session by asking how the client has been feeling since he or she had the blood sample drawn. Congratulate the client for returning or waiting for the results.
- If the client is known to have a history of drug or alcohol use, assess whether he or she is sufficiently alert and coherent to receive the result. It is not uncommon for individuals who are awaiting results to manage their anxiety by self-medicating.
- When the client is ready, let him or her know the test results in a neutral tone of voice and wait for the client to respond before proceeding. Say, "Your test result was positive. That means you are infected with HIV."
- Give the client time to absorb the information before proceeding. Make sure that he or she has understood the test results and absorbed the information mentally and emotionally. A prolonged silence or no response could be due to shock, denial, or helplessness. Check to see if the client understands the result:"Can you tell me what this means for you?" You may also want to ask, "I'm wondering what you're thinking or feeling right now…" Often, however, clients will not be able to tell you what they are feeling and may instead simply react in one of the following ways:
- Crying: If the client starts crying, it is important to let the crying continue. Give the client space to vent the feelings. Offering a handkerchief is one way of showing that it is all right to cry. Comment on the process:"This must be difficult for you. Would you like to talk about it?"
- Anger: The client may start swearing or let anger burst out in other ways. Do not panic, stay calm, and give the client space to express his or her feelings. Acknowledge that the feelings are normal and let the client talk about what is causing the anger: "I understand that you are angry, shocked, and upset…"
- Denial: Counseling should acknowledge the client's difficulty in accepting the information. Let the client talk about his or her feelings, The client can also be reminded of the precautions taken during blood collection to ensure that the blood sample was not wrongly labelled.
- Assess the client's ability to cope with the diagnosis in the next 48 hours. The assessment will include support available to the client and the risk of suicide (these will be covered in detail in chapter 5).
- How much you discuss partner or family disclosure with clients at this point requires careful consideration. Most clients will be too distressed for a detailed discussion. Briefly emphasize the importance of disclosure, going into details only if the client desires support in doing this immediately and if his or her emotional state will allow disclosure planning. It may be necessary to make further appointments. Chapter 7 of this handbook addresses partner disclosure counseling.
- Provide only brief information on HIV treatment and care and advice on healthy living. Most clients will not be able to absorb information at this point. But information need to provide that there is treatment available which can control the infection, prevent from disease progression and transmission to their partners and children. You could have information leaflets available for the clients to read when they wish and set up a further appointment to discuss this information.

- Provide follow-up appointments and referrals. All newly diagnosed clients should be referred for medical consultation as soon as possible. With the scale up of ART centers,in all districts of Nepal has ART/ ART Dispensing sites from where medicines can be started with consultation with trained staff, so rapid initiation of ART (same day or within 7 days of diagnosis) and benefits of treatment to be provided. HIV-positive clients can be referred to services that offer medical Even in areas where ART is not available, HIV-positive clients can be referred to services that offer medical prevention and treatment of OIs such as TB or PCP. Counselor should encourage HIV-positive clients to seek early treatment if they become ill, particularly with STIs and other OIs
- Offer follow-up counseling sessions to assist the client in adapting to the diagnosis as soon as possible. Where possible, provide an after-hours emergency contact phone number. This should not be your personal phone number but rather the contact number of rostered"on-call staff", the local crisis services, or even the local hospital accident and emergency department. Encourage clients who have tested positive to contact other HIV-positive individuals (through a network or support group or individually).
- Ensure client safety by asking how he or she plans to travel home. Often clients are in a state of shock and may put themselves and others at risk if they travel home in that state. Clients who seem disoriented can be offered tea, coffee, or even a place to sleep if possible. You could walk around the perimeter of the facility with the client until you are sure the client can negotiate traffic on foot or in a vehicle. Alternatively, you could ask the client if you should call somebody to take him or her home. This may, however, require some explanation to the other party and should therefore be considered carefully.

Chapter 5

Working with Suicidal Clients

Suicide risk in HIV

There are two periods when people with HIV are more likely to attempt suicide. The first is when the person is initially diagnosed and suicide may be an impulsive response to the emotional turmoil that follows. The second period of high risk occurs late in the course of the disease, when complications of the central nervous system resulting from AIDS develop, capacity to earn income declines, and people feel they are a burden to family members and care takers

Section 1: conducting a suicide risk assessment

How do I identify suicidal clients?

Many health workers fear explicitly addressing suicide with clients in the belief that this may"give the client ideas". On the contrary, sensitively inquiring whether a client has suicidal thoughts will communicate that you care for the client, and that you understand that sometimes life crises seem overwhelming. You can help prevent suicide only if you know it is a risk.

How do I raise the issue of suicidal thinking with clients?

You need to consider the various points of client consultation and how discussions of suicidal thoughts can be sensitively initiated.

It is important to determine as early as possible in the HTC process who may be at risk of suicidal thinking. Many clients come for HIV testing with predisposing risk factors and crises that are evident before HIV diagnosis. This early collection of information provides valuable information that may help you provide positive results in a carefully planned fashion.

A sufficient history should be taken to determine whether the client has common risk factors such as drug or alcohol use, pre-existing psychological disorders, or other life-threatening illnesses such as chronic hepatitis that might predispose him or her to suicide. It is also imperative to ask the client whether he or she could disclose a confirmed positive result to others and whether significant others (partners, relatives, or friends) would be supportive. Research indicates that individuals who have little or no support at the time of diagnosis or who are likely to experience rejection from significant others may be at greater risk of suicide.

In addition, clients should be asked how they would react if they received an HIV-positive result. While many clients may not be able to predict accurately how they would respond, the information elicited may indicate that they are at risk of suicide. Clients could respond to this question by indicating that they would take their lives. When clients respond in this way, counselor must make inquiries as to whether clients have, under other circumstances, attempted suicide. Clients who make such statements in anticipation of an HIV-positive result should be reminded that their results may show that they are not infected, and that if they are infected support will be available to them when providing indeterminate results? Some clients who receive indeterminate (or inconclusive) results are convinced that the follow-up test will confirm that they are infected. Such clients should be reminded that they have not been diagnosed HIV-positive. Counselor should assess the clients'

coping strategies and directly raise the issue of whether they intend to harm themselves or attempt suicide while waiting for further testing.

Clients who indicated during pretest counseling that they are at risk of suicide or whose history shows predisposing risk factors should be asked explicitly whether the result has left them feeling that life is not worth living or whether they would commit suicide. When providing confirmed positive results? When HIV-positive results are provided suicide risk assessment should be conducted with all clients irrespective of whether they indicated suicide risk during pretest counseling.

Clients who indicated during pretest counseling the intent to harm themselves if the result was positive should now be gently reminded about this. The counselor could say:"During pretest counseling you told me that you would kill yourself if you received a positive result… Do you still think that this is what you will do?"

While many clients may express this intent in pretest counseling, many do not mean to follow through on that intent. Even so, it is important to assess the suicide risk further. If a client denies entertaining suicidal thoughts despite the intentions expressed earlier, you must explore why he or she would not attempt suicide now after receiving the positive results. You can thus determine whether suicide is a continued risk. Clients who cannot say why they would not attempt suicide may still be at risk.

For clients who did not indicate during pre-HIV test counseling that they would attempt suicide, the counselor should consider the background information they supplied and explicitly explore whether being diagnosed HIV-positive has given them suicidal thoughts. The counselor may say, for example: "When I give positive results to people, they sometimes indicate that they feel as if their life is over, or they want to harm themselves or even end their lives. I am wondering how you are feeling right now…if you feel like this or fear that you may feel like this in the near future."

Long-term follow-up of HIV-positive clients

Many counselors working with HIV-positive clients implement routine psychosocial assessment screening, which assesses mood, relationship and social supports, and financial and living difficulties regularly every three to six months. This allows counselor to identify psychosocial stress factors early and to work with problems before the client starts contemplating suicide.

Such an assessment should alert you to the following predisposing risk factors for suicide:

- a pre-existing mood disorder (depression, anxiety, or mania)–all of your HIV-positive clients should be screened routinely for these conditions (common signs and symptoms of clinical depression are listed in box 5.1);
- a current psychiatric disorder such as schizophrenia or bipolar disorder;
- the presence of other psychosocial stress factors (e.g., a relationship breakdown);
- drug or alcohol use or withdrawal;
- inadequate pre-HIV test and post-HIV test counseling;
- inadequate support network; and
- Discomfort with sexuality or gender.

Clients are confronted with stigma, discrimination, family relationship breakdowns, loss of income, and many other social problems directly or indirectly related to the course of their illness. An explicit suicide risk assessment should be part of this routine psychosocial assessment. You could make this risk assessment during the routine follow-up by asking questions in the following way:

"Many people living with HIV feel that the problems that face them are overwhelming and that they cannot cope. Some even say that their life is not worth living and that they want to end it all'… Do you ever feel this way ?

Signs and symptoms of a clinical depression

Depression is an internal "stress state". To an outsider, the symptoms seem to be a form of agitation or withdrawal. However, each depressed person experiences the condition differently. The symptoms vary in severity by individual and over time.

- feelings of hopelessness, pessimism;
- feelings of guilt, worthlessness, helplessness;
- loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex;
- decreased energy and fatigue;
- difficulty concentrating, remembering, and making decisions;
- insomnia, early-morning awakening, or oversleeping;
- appetite and weight loss, or overeating and weight gain;
- restlessness, irritability;
- persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain;
- thoughts of death or suicide, suicide attempts.

Source: National Institute of Mental Health website:
www.helpguide.org/mental/depression_signs_types_diagnosis_treatment.htm

Therapeutic assessment interview. A good assessment interview is part of therapy. Often it is enough to change suicidal thoughts, especially when clients are impulsive and responding to an immediate emotional crisis such as a recent HIV diagnosis or a precipitating life event such as a marital breakdown or infidelity. Once you have established the presence of suicidal thoughts or you have noted a number of the previously mentioned common predisposing risk factors in the client's history you should conduct a detailed therapeutic assessment. A summary of this assessment is provided in box 5.2.

- Establish the presence of suicidal thoughts and their frequency.
- Find out the extent of planning for suicide (giving away of property, specificity of plans, etc.), including access to the means (pills, guns, etc.). Explore details of past attempts. Ask:
  - Were these impulsive, planned, carried out while using drugs or alcohol ?
  - How did this attempt change the client's life ?
  - How did others respond to the attempt ?
- Check for history of clinical signs of depression (refer to box 5.1)
- Explore other problems – HIV will rarely be the sole problem; often there will be other problems that confront the client.
- Explore what would make the client change his or her mind and want to live.
- Ask the client to consider the adverse impact of the suicide on others. Often clients think their death will bring relief to others; counselors need to challenge this notion.
- Develop a management plan and set goals for the client.
- Document your interview and determine the level of suicide risk.

Key procedural considerations in working with suicidal clients

- When a counselor is dealing with a suicidal client, it is important to first clear the client medically. Before starting counseling always find out from the client whether he or she has taken anything

poisonous. Do not be too quick to sit down and give counsel when the client could have ingested something toxic.

- In some cases the client comes in a crisis and requires urgent attention; he or she may be alone or accompanied by a relative. The counselor should see the client alone at the start. Many suicidal clients feel powerless and often unwilling to be frank and open about their problems in front of other members of the ”problem system”.
- It is important for medico-legal reasons to document your assessment of the client and your determination of suicide risk. You may have to justify action or lack of action at a later stage.
- Counselor should never leave a suicidal client unattended in a room during the counseling session. If you need to get a file or speak with another colleague stay in the room with the client and have another staff member assist you.

Documenting the assessment process. For medico-legal reasons the counselor must retain records showing that the client was assessed through standard clinical operating procedures.

The most appropriate form of documentation is a standard set of interview questions with the client's responses recorded against each item.

Determining the level of risk. All suicide risk assessments must gauge the level of risk; this will form the basis of your intervention. For medico-legal reasons the counselor must determine the level of risk against standard indices or assessment protocols. Two such instruments-the suicide risk assessment interview and the suicide matrix–may be found in the Tools for HIV Counseling. Choose the instrument that you feel matches your ability to assess the risk of the client. Professional counselor, psychologists, and medical personnel should use the more detailed assessment tool. Documenting the level of risk is important as it may be used to justify action taken by the counselor and other staff. For example, under mental health legislation clients may be detained against their wishes when there is a clear danger of harm to themselves or others. Similarly, breaches of confidentiality may be justifiable when clients' life is at risk.

Section 2: suicide management interventions

What do I do after I complete the assessment? After determining the level of risk, it is important to provide feedback to the client and make an attempt to engage him or her in the development of an action an. The action plan will depend on the client's level of suicide risk.

Key interventions for low-risk clients

- Provide feedback to express your continued concern about a possible resurgence of suicidal impulses.
- Ask the client to choose one person (a family member, partner, or friend) with whom the thoughts of suicide can be shared. The counselor could offer to meet with the client and the person chosen. Remind the client that there is no need to explain his or her HIV status. The other person simply has to be told that the client has been under a great deal of pressure and has thought of ending his or her life.
- See to it that the individual has immediate 24-hour access to suitable clinical care (e.g., crisis team, extended-hours team, general practitioner, hospital, or telephone support). Give the individual a list of contact numbers and provide explicit contingency plans in case these contacts are unavailable (see box 5.3). The client could become suicidal again, so these are important considerations

- Remove all available means of suicide (e.g., guns, pills, chemicals, car keys, knives, rope, other weapons). If the individual requires medication, limit access to the medically required amount and ask family or a friend to supervise.
- Get the client to identify and monitor early-warning signs of a resurgence in suicidal thoughts.
- Establish a suicide contract: try to delay the individual's suicidal impulses. For example, make a "contract" with the individual in which he or she promises not to attempt suicide within an arranged (short) period of time. Also, provide other options for the individual to use at times when he or she is on the verge of attempting suicide (e.g., suggest that the individual call someone reliable for help, such as yourself, a trusted family member or friend, a doctor, or a crisis hotline).
- Restore hope. Encourage the view that all problems can be managed if not solved. Identify, explore, and validate the client's ability to cope with past crises or difficulties. Use a structured problem-solving method (discussed in chapter 3) as an important skill for the individual to learn.

Providing emergency services after clinic hours

Believing that you are the only one who can help a client can be gratifying, but it is also unrealistic and harmful.

- Do not under any circumstances promise to always be available to clients. Clients should be encouraged to involve family member, friends, religious personnel, and other community agencies in caring for them.
- Encourage the formation of a support network (e.g., family, friends, and agencies).
- Encourage the use of community resources (e.g., crisis hotlines, peer support and community clubs, and medical centres) in case you are not available when the client needs you.
- Clients may need referral to specific agencies for assistance (e.g., legal aid, welfare organizations supporting unmarried mothers, single parents).

Counselors are advised to give only professional, and not home, contact information to clients. If after hours crisis contact is required by the counselors' employer, the latter should provide a special mobile phone and only this number should be given to the client on the understanding that the counselor may not always be available but a trained counselor will always be on hand to answer the phone. Different counselors on a crisis after-hours roster may take this phone.

Key interventions for clients who display little emotion after diagnosis or precipitating crisis

Clients who express sentiments like"I feel dead already" show serious immediate risk of suicide. These clients are often frank about intending to kill themselves eventually, but they will sometimes deny this intent in order to be released from the counseling centre. Some clients are in total denial of anger; in most cases these have a history of childhood abuse. These clients need to be referred where possible to a qualified psychotherapist, clinical psychologist, or preferably a psychiatrist.

Key interventions for moderate- to high-risk clients

How you respond and the degree of your involvement in supporting these clients will largely be determined by your professional background, the availability of other mental health services, and mental health legislation. The following steps are only intended to guide your response.

- Counselor should always provide feedback to clients they believe to be significantly at risk of suicide to let them know that they care for them and see that they have reason to live.

- A counselor who wishes to refer a client for further assessment by a specially trained mental health professional should let the client know. The counselor should always gain the consent of the client. It is always best if the client were to voluntarily seek admission to mental health services or hospital for supervision.
- If the individual is believed to be at high risk of doing harm to himself or herself and will not accept help, it may be necessary to talk to a psychiatrist or general practitioner about the possibility of involuntary admission to a hospital under existing mental health or public health legislation. Counselor should be fully aware of local mental health policies and legislation.

Where there are no suitable options for inpatient supervision, counselor should contact family members and seek their supervision and support. The issue of confidentiality will be overridden to some extent if the counselor believes the individual is acutely suicidal. Confidentiality about HIV status may be preserved; however, the counselor who has a client at high risk of suicide must inform others of the client's suicide risk.

Challenging client situations

There will always be individuals who are more difficult to help than others. Some special problems that may be encountered are discussed below.

Client who refuse to talk. An individual may refuse to discuss a previous suicide attempt or current thoughts or plans for fear of being:

- stopped from committing suicide;
- embarrassed by suicidal thoughts or attempts;
- labelled "mentally ill";
- sent to hospital; or
- exposed if details of the interview become known to others

or simply because the individual is being contrary or manipulative.

Naturally, the individual is correct in thinking that he or she may be prevented from committing suicide. Furthermore, if the counselor believes that the individual is acutely suicidal and will not accept help, the issue of confidentiality will be overridden to some extent. The counselor in that case may have to talk to a psychiatrist or general practitioner about the possibility of having the client admitted to a secure mental health facility or supervised inpatient hospital under national mental health legislation.

With regard to the other reasons for refusing to talk, the counselor can convey willingness to help and reassure the client about the confidentiality of the interview. A non-judgemental manner will be extremely important. If the client is still reluctant to talk, make sure he or she knows how to contact a clinician at any time of the day if the client should decide to seek help.

Clients who repeatedly attempt suicide. These individuals often feel lonely and isolated and may be trying to get attention. Alternatively, they may threaten or attempt suicide to control or use others to their own advantage. Other individuals may simply lack more appropriate coping techniques. Regardless of the reason, all suicide attempts need to be taken seriously. Counselor must remember that the individuals are in distress and may lack more appropriate ways of dealing with their emotions.

Although a clearly defined management plan should be established and followed, other crises will sometimes interfere with it despite the best intentions. In some cases involving individuals with a psychiatric disorder, such as a borderline personality disorder, certain behaviors or crises may need to take precedence over the management plan or other goals that the counselor and the individual have agreed on. These behaviors, listed in order of importance, are as follows:

- suicide threats, suicide attempts, and other life-threatening behaviors.
- behaviors that interfere with the process of treatment (e.g., missed sessions, excessive demands, angry outbursts, repeated admissions to hospital);
- Behaviors that seriously interfere with the individual's quality of life (e.g., drug or alcohol abuse, antisocial behaviors).

The rate of suicide completion among individuals with this personality type, although lower than that among people with schizophrenia and affective disorder, is substantial. Therefore, all suicide attempts need to be taken seriously even if they appear to be intended to manipulate others and seem unlikely to be lethal. As suggested above, the first target of management will always be high-risk suicidal behaviors. It has been argued that previous suicide attempts are among the best predictors of suicidal behavior. There are suggestions that problems in interpersonal relationships, depression, and drug and alcohol abuse are also risk factors in this population.

Suicidal threats or ideas need to be assessed immediately and actively. Once the individual's safety is assured, the goal of any intervention will be to replace suicidal behaviors with more adaptive ways of solving problems. Engaging the client in collaborative and structured problem solving may be a more constructive way of addressing his or her need for attention.

Making suicidal behavior a management priority with these clients has several advantages. First, it reduces the likelihood of future suicidal behavior. Second, it communicates the fact that the counselor or clinician takes such behavior very seriously. Third, the individuals themselves soon learn that if they engage in such behavior, they will spend their time with the counselor or clinician discussing this behavior and applying the problem-solving model rather than discussing other topics. Fortunately, suicide completion in these individuals becomes less likely as they get older.

Follow-up monitoring and counseling for suicidal clients

Low- to moderate-risk clients. You must organize follow-up assessment visits with clients. Low-risk clients should be seen and assessed for suicide risk regularly. If your service does not provide ongoing counseling, the client should be referred to an agency that provides such support. It is preferable that you either accompany the client on the initial visit to the agency or arrange for a family member or friend to do so with the client's permission.

Clients who have been prescribed antidepressants by a doctor. Antidepressants usually start to lift depressive mood symptoms after a period of two or more week after initiating the treatment. However, the psychomotor retardation that is often associated with depression tends to lift before the mood improves. Consequently, there is a period of time when the individual remains depressed but becomes more alert and active and during this time may attempt suicide.

If the individual has just been started on antidepressants and is being managed within the community, his or her family or carers should keep a close watch and avoid leaving the individual unattended during this critical management phase. The individual should also be made aware of the antidepressant time lag. At first, he or she may notice only side effects; it may be useful to explain that these indicate that the medication is starting to work.

Clients who acknowledge recent failed suicide attempts. Some methods of suicide seem "less" harmful but may cause serious complications. For example, an overdose of paracetamol can lead to liver failure and subsequent death. Unfortunately, some individuals overdose on paracetamol only to get help and attention without intending to kill themselves. Deaths among these individuals are especially tragic. After a suicide attempt the individual's physical health will need to be closely

assessed and monitored by a physician. Relapse into suicidal thinking is common among clients who have attempted suicide in the past.

Remember:

- Always review the precipitating risks and trigger for the past attempt at suicide.
- Always review the thoughts and emotions (feelings and body sensations) that may be the client's early-warning signs of depression. Ask the client to call the counseling service or a trusted family member or friend if a relapse seems imminent.

Chapter 6

Introduction to HIV Care Counseling

Care counseling is provided to people living with HIV to allow them to have a better quality of life and avoid passing on the infection to others, while improving the efficacy of treatment. Care counseling respects the rights and needs of HIV-positive people to enjoy sexual relationships, make reproductive choices, and live full and healthy lives.

Role & responsibilities of counselor

Key counseling tasks are as follows:

- periodic review of the client's commitment and ability to reduce transmission risk-the difficulty of sustaining behavior change should be acknowledged;
- encouragement and facilitation of voluntary disclosure of HIV status to partner and family (chapter 7);
- counseling for treatment adherence (chapter 8); and
- periodic psychosocial assessments to assess the quality of life of the client (including the client's mental health and ability to gain access to emotional support) make appropriate referrals for treatment, and provide financial and social support (a routine psychosocial tool, the post-diagnosis follow-up form, is provided in toolkit T6.1).

Section 1: HIV and mental health

Individuals infected with HIV and their significant others such as partner or partners, family, and friends can experience profound emotional, social, behavioral, and medical consequences. Adjustments will have to be made in partner relationships, family life, sexual and social relations, work and education, spiritual beliefs and needs, and legal and civil rights. The psychosocial issues are dynamic and are often different at different stages of the disease continuum. The HIV disease demands a great deal from the infected individuals and their significant others, and health workers must constantly adapt and adjust to meet these demands. Psychiatric disorders in persons living with HIV have been associated with poor treatment adherence, increased transmission risk behavior, increased drug and alcohol use, and poorer quality of life.

Counselor needs to support people living with HIV to be aware of the complex, and sometimes subtle, psychiatric and psychosocial issues. A psychosocial assessment, of the client's well-being and the risk of future psychiatric problems, as well as the client's social welfare needs, should be done routinely at least every six months or (preferably) quarterly. Most HIV-related psychiatric conditions can be treated with appropriate medications and psychological counseling and, if not cured, at least controlled.

Key considerations in supporting HIV-positive clients and their families are as follows.

Presence of a pre-existing mental illness or disorder

Research shows us that those individuals with a pre-existing history of psychiatric disorders may be more vulnerable to HIV because of their lifestyle and their limited capacity to modify transmission-related behavior.

Psychological reaction to living with HIV

The emotional reactions of clients may be a psychological reaction to the life changes that living with HIV brings. These changes include relationship break-ups, stigma and discrimination, loss of employment, and fear of death and bereavement.

HIV-related psychiatric or neurological disorder

This type of disorder is an effect of the virus on the brain or central nervous system (CNS). The most-common psychiatric or neurological disorders related to HIV are depression, anxiety (social phobia, health anxiety), psychosis, mania, and HIV-associated dementia.

Mood and behavior changes related to poor diet and nutrition

When clients eat poorly or have difficulty absorbing nutrients because of vomiting and diarrhoea, they may present with symptoms consistent with depression: apathy and inattentiveness, and problems with concentration and memory. People with some HIV-related neurological disorders often have these symptoms.

Side-effects of HIV and other treatments

Some antiretroviral (ARV) and other treatments can cause sleep disturbances, depression, agitation, and, in rare cases, even mania. Additionally, prescribed and non-prescribed drugs used together can interact and cause symptoms that could be misunderstood as signs and symptoms of a psychiatric illness.

Impact of HIV

HIV can be diagnosed at any stage of the illness. Indeed, many individuals do not know their HIV status until the later stages of the disease. The following is a summary of the key considerations occurring at different points in the course of the disease.

Post-initial diagnosis. Diagnosis of HIV is often accompanied by feelings of shock, anger, disbelief, and even denial. After diagnosis, clients will go through an adjustment phase of mild to moderate intensity and limited duration. However, evidence indicates that among some individuals adjustment disorders will be more significant. Clients may present with depressed moods and anxiety, and initiate or increase drug and alcohol use. Some of these conditions may, however, precede infection and could be associated with behaviors that put a person at risk of acquiring HIV.

Suicidal thinking is common around the time of the initial HIV diagnosis; these feelings may continue for up to six months (and sometimes even longer). Another condition diagnosed in individuals during this phase of illness is post-traumatic stress disorder, a severe form of anxiety particularly prevalent among individuals with HIV acquired through sexual assault.

Many of the psychological problems at this stage respond to simple counseling interventions to help the client with specific tasks. These interventions include the following:

- assessing and managing suicidal feelings (see chapter 5);
- supporting clients in disclosing their HIV status to their partner or family (see chapter 7);
- supporting behavior change to reduce HIV transmission and maintain health (see chapters 3 and 9); and
- responding to specific problems that are related directly or indirectly to living with HIV.

All clients who are newly diagnosed must be referred for medical follow-up to a doctor who has been trained in HIV treatment and care. The client may also need STI or TB assessment and treatment, along with interventions to prevent mother-to-child transmission (see chapter 9).

At this stage you will need to acknowledge the very real challenges confronting clients living with HIV. Fluctuating emotions will have to be normalized. Statements of understanding can be helpful; for example: ”I understand this is difficult for you. Many clients I see experience a wide range of emotions at different times as they adjust to this diagnosis. Many clients tell me they move in and out of crying to feeling angry, feeling hopeless and then hopeful. These feelings are not comfortable but it is normal to respond in this way. You are not losing your mind. You will not always feel this way.”

Asymptomatic phase. The asymptomatic phase of the illness can last up to 10 years in treatment-naive patients (those who have not begun HIV treatment) or much longer among those with access to early intervention treatment. During this phase individuals are typically symptom-free or experience only mild symptoms but may present with difficulties related to coping with lifestyle changes and living with an infectious disease. Some may develop health anxiety and misinterpret minor non-HIV-related health symptoms as indicators of disease progression. People in this stage may also have to deal with issues related to the disclosure of status, rejection, and discrimination. In HIV-prevalent areas, some people may suffer multiple bereavements as partners, family, or friends die from HIV and may develop anticipatory loss reactions related to their own sero-status. The diagnoses most commonly provided during this phase of the illness are adjustment disorder, depression, drug and alcohol misuse, panic disorder, personality problems, and either psychogenic or HIV-related sexual dysfunction.

Symptomatic phase. The third phase occurs typically within five to 10 years after initial infection. People living with HIV experience significantly more psychological issues as they progress to this third phase of the disease. High levels of anxiety and depression are noted with the onset of HIV-related symptoms. Other common diagnoses are:

- organic brain syndromes such as HIV dementia;
- delirium related to opportunistic infections;
- drug and alcohol dependency and misuse;
- mood disorders related to metabolic disturbances;
- chronic pain; and
- HIV-related constitutional illnesses.

In addition, HIV-related sexual dysfunctions are more likely to be reported during this phase of the illness and these may present challenges to HIV transmission risk reduction.

Specific counseling tasks include the following:

- assessing and managing suicidal feelings (see chapter 5);
- providing clients with support related to partner or family disclosure (see chapter 7);
- supporting behavior change to reduce HIV transmission and maintain health (see chapters 3 and 9);
- responding to specific problems that are related directly or indirectly to living with HIV;
- screening for HIV-related psychiatric and neurological conditions;
- counseling for treatment adherence (see chapter 8); and
- grief and bereavement counseling (see chapter 10).

Acquired immune deficiency syndrome. AIDS is the final stage of HIV disease. The mean survival rate without ART is about two years after an AIDS-defining illness is diagnosed. In this phase of the disease, organic brain syndromes such as AIDS dementia complex, HIV mania, and organic mood disorders may be the dominant presenting problems in psychiatric consultations. During this phase clients may experience adjustment disorders related to disease onset, loss of autonomy, grief and loss, and increased suicidal thoughts. Psychological assessment diagnosis in HIV requires the

practitioner to consider the relative contribution of metabolic disturbance, constitutional illness, pre-morbid conditions, iatrogenic effects, and psychosocial factors to mood and behavioral disturbance.

Many of the issues and tasks for counselor will be the same as in the previous phases; however, the emphasis may shift to these other tasks:

- finding financial, housing, and social support for clients who can no longer work;
- providing grief and bereavement counseling (see chapter 10);
- advising and supporting families, friends, and health workers in managing challenging patients with HIV-related psychiatric and neurological conditions;
- preparing adults and children (see chapter 9) for periods of inpatient hospital treatment;
- arranging for substitute care and long-term care of dependent children (see chapter 9); and
- gaining access to home-based care and support services.

A summary of common signs and symptoms of HIV-related psychiatric disorders can be found in annex 3.

Mental health assessment

Conducting a post-diagnosis review. First and foremost, review your client's pre- test and post- test counseling notes. If your client has been referred from another agency and counselor you may not have access to his or her records and must therefore conduct a psychosocial assessment. A tool for post-diagnosis counseling can be found in HIV Counseling Tools (with this handbook). This tool will guide counselor in assessing how the client adjusts to their diagnosis.

Diagnosing and referring clients for assessment and management of psychiatric disorders. Diagnosis of HIV-related psychiatric conditions should be conducted only by appropriately trained individuals including clinical psychologists with training in clinical diagnosis, psychiatrists who can prescribe medication, and neurologists. Many specific diagnostic tools are licensed for use only by trained mental health practitioners. Among these are specific mood disorder diagnostic tools, the International Classification of Diseases (ICD 10), and the Diagnostic and Statistical Manual of Mental Disorders (Revised) (DSM IV R)[k1]. The References section of this handbook lists some useful clinical diagnostic tools. As discussed earlier, some psychiatric conditions that counselor will see in clients will not respond to simple counseling and problem solving alone and will require medication. For this reason, clients need to be referred to a medical practitioner with mental health training. In most cases these clients will be prescribed medication and may be referred back to you for counseling or referred to peer support. In some cases clients will require inpatient treatment to stabilize their mental or medical condition. A series of flow-charts have been included in the toolkit to assist clinical diagnosis. Again these flow-charts must be used with caution; they are intended only to assist in diagnosis and referral.

Psychiatric referral and treatment, social welfare counseling, and peer support all play an important part in post-diagnosis care, support, and treatment plans. Counselor will need to bring to their interventions with clients an atmosphere of empathy, respect, and encouragement. Many clients will present to us with a sense of ambivalence about whether they can trust a counselor or whether a counselo can really help them, and some may even appear defensive about needing our assistance.

Section 2: developing a post-diagnosis support plan

A client will have many emotional, spiritual, and economic needs. To address these needs, it is important to develop an individual action plan and, where feasible, to identify a case manager (the preferred term is client support coordinator) , social worker, or counselor who can provide continuous

care and support and assist the client in negotiating complicated medical and social service systems. Case management involves assessing needs, developing an individual action plan, and providing follow-up services.

Remember:

- A trusting relationship between the counselor and the person living with HIV and AIDS is integral to providing adequate assistance and follow-up services.
- The counselor should be sensitive to the individual needs of each client when providing assistance and developing action plans.
- The counselor should have extensive knowledge of available clinical, community, and social service systems, along with a basic understanding of counseling skills.
- Counselor should address the Positive Prevention aspects for people living with HIV, not only giving emphasis on transmitting to others but protecting themselves from getting new infections.)

Developing follow-up and referral plans

In the context of HTC, referral is the process of assessing and prioritizing immediate client needs for prevention, care, and support services, and assisting clients in gaining access to these services (e.g., by making appointments or providing transportation). All CT centers should develop a referral directory including addresses and contact details of the referral sites .Referral should include the basic follow-up necessary to facilitate initial contact with care and support service providers.

Clients' care and support needs change as HIV infection progresses. Although counselor cannot fulfill all client needs, they can mobilize additional resources to reinforce the care and support they offer. This requires the involvement of the family, community, religious groups, self-help groups, nongovernmental organizations (NGOs), development partners, health-care facilities, and others. Counselor should refer clients to services that address their highest-priority needs and are appropriate to their culture, language, gender, sexual orientation, age, and developmental level.

Counselor must be aware that there are limits to the services they can offer. These limitations should be explained to clients clearly so they do not feel rejected if the counselor makes a referral. Counselor can refer clients during the pre- or post-test sessions (or at any other time) and must know how to make appropriate referrals with clear plans for discharging clients.

Reasons for referrals. Clients may have complex needs that affect their ability to adopt and sustain behaviors that will reduce their risk of transmitting or acquiring HIV. They may need referrals for medical evaluation, care, and treatment of OIs and communicable diseases (e.g., TB, hepatitis, and STIs). Referrals may also be needed for clients who need:

- treatment of a drug or alcohol addiction;
- care and treatment because of mental illness, developmental disabilities, or difficulties coping with an HIV diagnosis or HIV-related illnesses;
- legal services to prevent discrimination in employment, housing, or public accommodation;
- individual counseling;
- relationship counseling;
- family counseling;
- spiritual counseling;
- access to social services;
- home-based care; or
- Family planning services.

HIV-positive pregnant women and HIV-affected families with orphans and vulnerable children may need to be referred as well.

Assessing clients' referral needs

Counselor should identify the key factors that are likely to influence a client's ability to adopt or sustain behaviors that:

- reduce the risk of transmitting HIV or acquiring STIs;
- promote health; and
- prevent disease progression.

The assessment should include an examination of the client's willingness and ability to accept and complete a referral (see box below regarding measures intended to preserve confidentiality in the referral). Service referrals that match the priority needs identified by the client himself or herself are most likely to be completed successfully. Counselors may refer a client to clinical or community support groups, depending on the client's needs and responsiveness to counseling.

Making a successful referral

- Work with clients to decide what their immediate referral needs are.
- Outline the health and social service options available using referral directory and help the client choose those most suitable (in terms of distance, cost, and client's culture, language, gender, sexual orientation, age, and developmental level). Develop a referral directory of the available services in the area with contact details.
- In consultation with the client, examine the factors that may make it difficult for the client to attend the referred service (e.g., lack of transportation or child care, work schedule, cost) and address those factors.
- Make a note of the referral in the client's file. Follow up and monitor the referral process.
- Give the client a list of other services with addresses, telephone numbers, and hours of operation.
- Ask the client for feedback on the quality of the services to which he or she has been referred. Be aware of community support groups near the counseling site, the services they offer, their hours of operation, and contact persons.

In certain cases it may be most appropriate to refer clients (with their consent) to a family member, friend, or sexual partner. The counselor should discuss the matter of identifying a suitable party with the client. If possible, the counselor should meet with that person before sending the client to meet with him or her.

Section 3: mapping out the client's needs

Review your client counseling notes and assessments, determine the key issues, and then, one by one, identify specific intervention strategies. Let us look at an example in the case study below.

Case study. The client is a woman who was brought to the clinic by a female co-worker from the factory where she is employed. The woman has known she is HIV-positive since her first husband died two years ago. After her husband's death, her family sent her to live in your city with a relative. She met another man and they were married.

She has not told her husband that she has HIV and does not know about HIV preventive services. She also says that there is pressure from her husband and his relatives to start a family. She reports she is not using contraception at present and has unprotected vaginal sex with her husband.

Often unwell, she complains of recurrent diarrhoea and weight loss, loss of appetite, and decreased

sexual desire. In addition, she has a smelly vaginal discharge and itching. She also reports that she has a persistent cough and recently coughed up blood, and she finds it difficult to sleep at night. Her situation, she says, is hopeless. Her employer is upset because of the increasing time she is taking off work for illness. She no longer wants to talk to her friends at work. She has not had any HIV follow-up and has only limited knowledge of treatment options.

Issue	Strategies
Brought to the clinic by co-worker after crying at work; was not aware this facility was for HIV and now fears people suspect she has HIV.	• Suggest strategies for responding to questions from her co-worker regarding the clinic visit (e.g., "How did it go?") • Discuss how she can negotiate with this co-worker to maintain confidentiality
Reporting STI, HIV, and TB-related symptoms	• Refer to local TB service and medical doctor trained in HIV care and treatment • Refer for STI treatment if local HIV service does not offer service • Link to treatment and care team
Husband and family unaware of her status	• Provide counseling in support of disclosure to partner and family
No contraception, and unprotected sex with her husband	• Discuss risk of MTCT if she becomes pregnant • Offer pregnancy test or refer for pregnancy test • After partner disclosure offer to refer couple to family planning service • Discuss safer-sex strategies and the need to protect her from STIs, and other infections; offer condoms for contraception after disclosure to partner
Pressure from partner and family to have a child	• Obtain client's consent to conduct PMTCT counseling of partner and family after disclosure
Loss of appetite, decreased sexual desire, unwillingness to talk to friends at work, sleeping difficulties	• Assess/Refer for depression and drug and alcohol use • Teach relaxation exercises to assist with sleep Disorders
Lack of appetite and weight loss	• Refer to nutrition counseling service
Time off work due to illness	• Discuss strategies for explaining absences at work • Refer to NGO for financial assistance if required
Increasing social isolation	• Offer referral and introduction to peer support

HIV = human immunodeficiency virus, MTCT = mother-to-child transmission, NGO = nongovernmental organization, PMTCT = prevention of mother-to-child transmission, STI = sexually transmitted infection.

Chapter 7

Supporting HIV Disclosure

This chapter deals with partner and family disclosure between adults. The disclosure of HIV status to a child is discussed in chapter 9, section 2, of this handbook.

Section 1: counseling for HIV status disclosure

Counselor's role in ethical partner disclosure

One of the most challenging HIV prevention and care activities that a counselor will engage in is facilitating partner disclosure.

Partner disclosure counseling has long been part of the public health response to STIs other than HIV, such as syphilis and gonorrhoea.. But it does appear that when people think that they will be forced to tell their partners, or that their status will be revealed without their consent, they choose not to come in for HIV testing, counseling, or other prevention and care services. Counselor should always promote disclosure of HIV status to their partner or family member, however this process should be volunteer by the client. If the PLHIV clients are not ready, continuous support should be provided to facilitate disclosure. We will discuss the various strategies available to you for STI contact tracing later in this chapter.

What about clients who put their partners at risk by refusing to disclose their status?

In a voluntary partner counseling program, the few cases where persons refuse to tell their partners can be taken care of individually. The counselor should support and provide information on their responsibility to reduce transmission by continuing treatment and have VL suppressed. If in case of transmitting HIV infection to their partners knowingly , the counselor should make them aware about legal consequences for transmitting infections.

Clients may sometimes refuse to disclose their status because of a fear of violence. A protocol for dealing with this barrier is provided in annex 6.

When should I raise the disclosure issue with clients?

The best time to start discussing disclosure with clients is when they attend pretest HIV information session. When reviewing a client's exposure risks the potential need to discuss their status with partners should be addressed if they receive an HIV-positive test result. You should indicate that support would be offered to them in this area. As discussed in the HIV post-test counseling section of this handbook (chapter 4), a counselor may gently raise the issue when the HIV diagnosis is provided. It is also important to bring up partner disclosure during the regular counseling follow-up visits that are offered to individuals in the course of their HIV infection.

Initiating the discussion. Counselors should indicate to clients that they understand that telling partners is difficult but the benefits of disclosure outweighs the risk (table 7.1).

Facilitating decision making. Counseling is not telling people what to do. Rather it is encouraging them to think through the advantages and disadvantages of options and helping them come to an informed decision. It also is about helping them overcome the barriers that they may encounter. Research demonstrates that when solutions are imposed on clients, they are less likely to stick

to them. We can let our clients know that we need to work together to overcome any anticipated difficulties in order to:

- Allow partners to have early access to treatment and care;
- Reduce HIV transmission to uninfected individuals;
- Prevent re-infection with HIV and STIs; and
- Reduce the risk of HIV Drug resistance.

A counselor can assist clients in considering the benefits of disclosure to them as individuals and to their relationships with others, as well as its negative consequences. Because disclosure is a very private and individual decision, all relevant personal circumstances should be considered. Common advantages and disadvantages of disclosure and non-disclosure (table 7.1) should be weighed and compared. If the clients can read and write, it is helpful to draw up a matrix and have the client brainstorm about advantages and disadvantages. Alternatively, the counselor could make notes as the client answers aloud, and then provide an oral summary: ”You listed the following as advantages…and the following as disadvantages…”

Table 7.1: Disclosure or non-disclosure (a sample decision matrix)

Option	Advantages	Disadvantages
Disclosure of HIV/STI status	• Burden of secrecy is lifted • Emotional support is available Family and social support Treatment adherence support • Health care and medications are more accessible (no need to hide them) • Symptoms and worries can be discussed freely • (If disclosing to spouse or partner) Safer-sex and family-planning choices can be discussed freely • Reasons for specific activities (e.g., breast-feeding) can be shared freely • Partner can be tested and treated	• Person is distanced or rejected outright by partner, spouse, friends • Job loss is possible* • Children are shunned in school* • Promiscuous label is attached to person • Person is discounted because of fatal illness* • All signs or symptoms are assumed to be HIV-related* • Others fear for their safety around the person* • Person is at risk of mental or physical harm • Other • Associated with HIV discrimination and stigma
Non-disclosure of HIV/STI status	• Status is kept secret • Status quo (”normalcy”) or current situation is maintained • Person is protected against stigma, isolation, rejection, loss of income, violence, blame for change in social status • Person is not prevented from having children in the future • They are not forced to seek medical care that they do not need • Other	• Secret is a burden • Anxiety builds because of fear of involuntary disclosure • Social support is inaccessible • Person is isolated • Sexual partners are put at risk • Access to medical care is delayed • Trust of children, family is lost • Other

How clients consider and evaluate the advantages and disadvantages of disclosure is determined by their personality and their past and current life experiences.

Offering a menu of disclosure options. Another powerful way to support decision making around disclosure is to offer the client a menu of disclosure options (see box 7.1). Often clients feel that they cannot make the disclosure themselves, while others feel it would only upset their partner to hear the news from someone other than themselves. As a counselor you should support the client's decision making by presenting him or her with a menu of disclosure options and encouraging the client to discuss the advantages and disadvantages of each option.

Partner disclosure options

- Client discloses to partner
- Client brings partner/family to clinic and discloses with counselor present
- Client brings partner/family to clinic and counselor discloses in front of client
- Client authorizes counselor to disclose without the client
- Client discloses to a key trusted family or community member who discloses to partner
- Client hands out referral cards to sexual contacts

Once the client has decided on his or her preferred disclosure option, you can offer support in a number of different ways.

Preparing the client for disclosure, including self-disclosure. One key way to assist the client is to help him or her think through the why, when, where, how, and what of disclosure. While this is important for all of the disclosure menu options, it is particularly critical for client self-disclosure.

- Why: You need to make sure that clients think through why they are making the disclosure and what response they anticipate.
- When: Encouraging clients to consider the appropriate time for the disclosure is important. You need to have the client make the disclosure when no one else is present in the house to see the distress of the partner (e.g., the children are asleep). Clients should avoid making a disclosure during an argument.
- Where: Helping clients consider the place that they feel will give them the time for a confidential discussion and offer some security to both parties is an important consideration.
- How: You need to encourage the client to think about the disadvantages of different methods of self-disclosure (face-to-face or by telephone, email, or letter).
- What: Plan with the client how to initiate the conversation and anticipate the partner's likely response. You can then plan with the client a constructive response to the partner's reactions. Role-play can be an extremely useful technique to employ. When getting the client to anticipate how the partner will respond you can take on the role of the partner in the dialogue.
- Planning for next steps: Plan with the client how to get the partner support, HIV testing and counseling, and how to manage the relationship issues arising from the disclosure.

Partner disclosure by the client in the presence of the counselor

Role-play rehearsal is again important if the client will be making the disclosure himself or herself. All of the planning discussed for self-disclosure should be discussed before the session with the client.

As the partner may have questions for the counselor during the session, it is important that you clearly plan with the client in advance what can and cannot be disclosed during the session. It may be a good idea to document the permissible and non-permissible disclosure items in the counseling record form agreement.

Consider the following disclosure options:

- full disclosure–nothing is barred, client gives full consent; or
- partial disclosure–some things can be discussed (HIV status) but others cannot (e.g., sexuality; the way the person became infected; risky practices such as injecting, sex work).

Counselor disclosure in the presence of the client

If the plan is for the counselor to make the disclosure in the presence of the client then this should be role-played with the client after he or she has briefed the counselor in what to disclose and what not to disclose. Again, list what may be discussed by the counselor with the partner and what may not. Consider planning with the client:

- How you will introduce the disclosure to the partner;
- How the partner could react (check for the possibility of violence);
- How you will manage items that are not to be disclosed (e.g., how your client got infected);
- His or her role during the session (e.g., will the client answer questions?); and
- How he or she will initiate future conversations with the partner after the disclosure.

Counselor disclosure without the client

This type of disclosure is often referred to as voluntary third-party disclosure. A counselor must first gain written consent from the client before disclosing his or her HIV status to partners. Counselors are advised to make a list as to what can be discussed with the partner and what cannot.

This type of contact is sometimes better done by an independent counselor with only limited knowledge of the client's history, to prevent inadvertent breaches of confidentiality.

Issues to consider include:

- Where the disclosure is to take place (e.g., at home, the clinic)–if the disclosure is to be made at the client's home, at least two counselors should be present and consent for this should be obtained; if the disclosure is to take place at the clinic, consider the strategies or excuses the client will have to use to get the partner to come over;
- Whether there is potential violence related to the disclosure (either towards the client, or the client to the partner) ; and
- How the client will manage himself or herself with the partner after the disclosure, and what form of communication with the partner will be needed.

Disclosure by a key trusted family or community member on behalf of the client

This is another form of third-party voluntary disclosure where the client nominates a trusted family, religious, or community member or leader to make the disclosure on the client's behalf. Usually the person chosen has the respect of the partner or the client's parents or whoever else the disclosure is to be made to. This person needs to be counselled on what should and should not be disclosed. Care must be taken to support the client in fully exploring the willingness and capacity of the selected individual. Should the client decide to proceed with this method, the counselor could offer to assist the client in briefing and rehearsing the third party.

Section 2: partner contact strategies for other STIs

Often in STI services the counselor is also the doctor treating a client. If the counselor is not an STI doctor, all clients arriving at the service should be seen by a physician. The counselor must discuss with the client strategies for effective ethical contact with partners. If the purpose of partner

management is to treat as many of a client's sexual partners as possible, there are three ways of contacting sexual partners:

- through the client himself or herself (client referral) ;
- through a service provider (provider referral) ; or
- through a third party, without revealing the identity of the client (conditional referral) .

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- through a third party, without revealing the identity of the client (conditional referral) .

Client referral

In this option the client takes responsibility for contacting partners and asking them to come to the clinic for treatment. Many clients may be unwilling or unable to discuss the STI with partners, so the service provider should help him or her decide what to do. A client might approach partners in several ways:

- by talking directly about the STI infection and the need for treatment;
- by accompanying the partner to the health centre or asking him or her to come to the centre without saying exactly why; or
- by giving the partner a card asking him or her to come to the centre.

Provider referral

The partners of a client with STI are contacted by a member of the health team–perhaps the counselor or health-care provider who treated the client, or someone else with a particular role connected with searching for and treating partners. The provider obtains the names of the sexual partners but gives the client time to counsel them himself or herself before the provider asks them to come to the clinic for treatment.

Conditional referral

This is a third-party referral, where the provider counsels the partners without naming the source client concerned.

On the surface, all approaches to partner management suggest some advantages; you might like to spend a few minutes working out what they are. Considering the advantages and disadvantages summarized in table 7.2.

Table 7.2: Partner management approaches

Approach	Advantages	Disadvantages
Client referral	Client has control over decisions, so they are both voluntary and confidential No cost to the centre	Depends on willingness of client to refer partners Client may need support from service provider
Provider referral	If referral succeeds, more partners can be contacted and treated more efficiently.	Depends on willingness of client to divulge names Cost, time, and practical problems of tracing partners More, highly trained staff will be needed May be perceived by clients as a threat to confidentiality
Conditional referral	Partners who accept referral and test positive can be treated May reduce further transmission by the partner	Trust in health worker may be destroyed May distress the couple's relationship and reduce trust

Because of the expense of provider referral and the perceived threat to client confidentiality, the more practical option is client referral. This is also the approach recommended by WHO.

Client scenario

A young man comes to the clinic and tells you that a girlfriend asked him to come over to have an STI treated. He does not know the name of the syndrome and shows no symptoms or signs of any infection. The name he gives for his friend is not in your centre's records, so you have no way of identifying which syndrome to treat him for.

Client referral cards

Given the high proportion of partners with no STI symptoms, the scenario described in box 7.3 is not implausible. It is an example of failed partner management. If the partner shows no symptoms or signs of an STI, and the original client's syndrome is not known, the partner cannot be treated.

Client referral cards can help resolve this problem, and are used for this purpose by many health centres.

Sample client referral card A

Card No……..	Card No…….
Date of Issue:……..	Date of Issue:……
	Issuing Clinic: ,name of servicite
	Name:…….
Partner's name and details:……...	Please come to service site name and adress
……..	Please bring this card with you.

The card above has two parts. After the necessary details are written in, it is cut along the vertical line and the right half is given to the client to hand to the partner named on the card. The remaining half is kept in the centre's records. Cards like this can be linked with the record systems of several different health centres. More importantly, they allow the centre to record the names of partners who come for treatment, as well as those who don't, together with their contact information. This information would be useful when contacting partners through provider referral.

Sample client referral card B

Service Site……..

Tel. no……

Opening hours……..

Date: 10/4/021 Referral ABC

This second card is much simpler, yet it contains the information needed to treat a partner. In the sample above the service provider has merely written in the date and a code for the client's STI syndrome, "ABC", which could stand for any of the seven STI syndromes. Clients know the card is in general use at the centre; hence, no stigma is attached to carrying it around. It also contains no personal details on the client or the partner. The use of such a card, in short, has no disadvantages and can be part of an administrative records system (e.g., for monitoring the success of client referral).

Summary

A referral card can be extremely useful in helping counselors identify the appropriate treatment for anyone referred to an STI clinic by a client with an STI. The card may include any extra needed information, but should never breach confidentiality or put anyone at risk of being stigmatized.

Chapter 8

Providing Treatment Adherence Counseling

ART is a complex treatment with multiple medications that, once started, need to be taken over the , life-long term. Studies have shown that an adherence rate of over 95% is associated with the optimal response to treatment for the control of HIV replication. For ART to be effective, a patient must take all the prescribed medications regularly and at the same time every day. Some medications have other requirements: for example, they have to be taken before or after a meal, or with a certain liquid. Suboptimal adherence to the ART regimen can result in treatment failure, continued destruction of CD4 cells, and resistance to antiretroviral (ARV) medication. ARV resistance, aside from causing regimen failure, will compromise future treatment options and increase the risk of mortality. Non-adherence to medication requirements may also diminish their effectiveness.

How treatment resistance develops

In order to understand treatment resistance it is important, first of all, to understand ART. Multiple ARVs are used to interrupt the life cycle of the virus. *Viral load*–(the level of virus in the blood)–is dramatically reduced and restore the immune system damage through a cocktail combining at least three ARV drugs of various classes.

The development of viral resistance to treatment is a complex process. There may not be enough of the drug in the body because of incorrect or missed doses, by malabsorption caused by dietary or other problems such as diarrhoea or vomiting or other more complicated issues related to the natural history of the virus.

The counsellor's role

Your role as *adherence counsellor* is to provide key information about:

- how ART works;
- how treatment can fail; and
- how the common challenges to adherence can be overcome.

Clients need to know that if they do not take the ARV medications with a very high degree of adherence the medications will stop working, both for the individual and for the whole community over time, as a result of resistance. First-line treatment is the most effective and easiest to take (with fewer side effects than second-line treatment). First-line treatment can give years of life to the patient, assuming near-100% adherence. Second-line treatment is harder to take and more expensive.

In relation to ARV medication, infected patients have been known to share their drugs with an uninfected partner to keep him or her from catching the infection, or with other HIV-positive family members who are asymptomatic and do not yet need ART, to prevent illness. Clients should be warned against sharing drugs with others, as this may result in insufficient levels of the drugs in the body and the development of ARV resistance.

How to support treatment adherence and minimize the chances of treatment resistance

It is extremely important that clinical services establish a system where they take time to assess and prepare individuals for long-term treatment. In particular, counsellors will need to consider the

diverse needs of individuals from most-at-risk populations. The general principle is that the individual does not commence therapy until he or she:

- has emotional and practical life support systems (e.g., family members, friends, community volunteers, or members of PLHIV clubs) to support him or her;
- can work his or her treatment regimen into a daily routine;
- understands that non-adherence leads to resistance and that this can be passed to others through unprotected intercourse or the sharing of injecting equipment;
- recognizes that all doses *must* be taken as prescribed (the correct dose in the correct way at the correct time);
- understands that traditional medicines and special dietary supplements may adversely affect ART and health, and that their use should be discussed with the treating physician;
- feels comfortable taking treatment drugs in front of others (has disclosed to others or has a prepared explanation for taking the pills);
- keeps clinical appointments;
- knows ”alarm signs” and when to see a doctor about them;
- understands the interaction and side-effects of ARVs in combination with illicit drugs and, where applicable, oral substitution therapies; and
- knows how to manage common side-effects of the medications (e.g., nausea, vomiting, diarrhoea).

Throughout adherence counseling, the counsellor will need to work in close collaboration with the doctor, nursing staff, and home-based care team.

ART adherence counseling and prevention of HIV and other STIs

It is difficult for patients to adhere to HIV ART if they cannot disclose their status to their partners and family members who live with them. You must raise the importance of disclosure to partner and family and facilitate the process. It is also important to support your clients in encouraging their partners to be tested for HIV if they do not yet know their status.

Counseling seroconcordant couples

The potential risk of HIV superinfection has been used to support recommendations for the correct and consistent use of condoms even when both partners are already infected with HIV. Though the issue is a complicated one, it is difficult to find strong evidence to support condom use among monogamous, seroconcordant, HIV-infected couples to reduce the risk of superinfection. If either partner has sex with others, however, then the correct and consistent use of condoms is strongly advised for the couple to avoid STIs.

Concordant HIV-infected couples should use condoms consistently if needed to avoid STIs and unintended pregnancy. Not enough is known about HIV super infection, however, to recommend consistent condom use specifically to prevent super infection.

Pre-treatment preparation counseling

National HIV testing and treatment guidelines recommend same day or within seven days ART initiation. Therefore, it is not necessary to provide three adherence counseling session before treatment start. However, we will continue to provide adherence counseling at initiation of treatment, in 15 days when client comes to treatment center for first follow up and consecutive drug pick up.

During each visit some of the information provided in the previous visit can be reviewed and the client's understanding should be assessed.

The impact of psychiatric and neurological disorders

As discussed earlier, psychiatric and neurological disorders are common in HIV and can pose substantial challenges to maintaining treatment adherence. Difficulties with planning and scheduling daily activities, attention and memory problems, and poor motivation–features of many of these disorders–may keep the individual from adhering to the treatment. In HIV-related dementia, psychosis, or mania, individuals may refuse to take medication, believing it to be poison. Individuals who experience paranoid thinking may resist the support offered by others.

Adherence counseling before providing treatment

- Explore the client's knowledge and understanding of HIV and his or her own health status.
- Briefly introduce the concept of ART, show medicine and tell when to take medicine and other treatments to the client, share the treatment plan
- Explain potential side effects which may develop after taking medicine, explain the ways to overcome, also tell the client when client needs to seek the support from ART center
- Explore potential barriers to adherence. Explain about the personal reminders, also explain that they will get call from ART center when they do not show up on time. Record their phone number, verify the number by dialing it.
- Explain the consequences of non-adherence.
- Discuss the importance of disclosure in the family or with a friend so that that person will support the client for continuing treatment, (remind client taking medicine on time)
- Explain the role of community workers (CHBC workers or peer navigators), ensure that these workers will not breech the confidentiality of the client, they are available in the community for any help the clients needs in future
- Assess the client's readiness. You can facilitate this assessment simply by asking the client to answer your questions about the regimen and what the client proposes to do when there are problems.
- Refer below for the support during treatment and during follow up

Treatment follow-up sessions

- Review of treatment experience of client
- Assessment of any need for referral back to doctor
- Monitoring of adherence
- Review and problem solving of barriers to resistance
- Review of adherence to transmission risk reduction plan
- Psychosocial assessment

The impact of psychiatric and neurological disorders

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- Counsellors should screen for the presence of the disorders using the adherence pretreatment screening tools (”Pre-ART adherence screening tool (T8.4)”. It is important that you discuss the findings of this assessment with the patient’s doctor. Further reading on this topic is essential; recommended references can be found at the end of this handbook.

Managing common barriers to treatment adherence

The individual client may be inhibited from adherence for any of the following reasons:

- A lack of understanding of the treatment regimen and goals;
- Barriers to motivation and memory;
- Support and logistical barriers; or
- Treatment side-effects.

Barriers to understanding originate from poor communication, language barriers, low literacy, lack of knowledge and erroneous beliefs about HIV as a disease, and lack of awareness or mistrust in the effectiveness of ART. On the other hand, barriers to motivation and remembering can stem from forgetfulness, depression, or other psychiatric conditions, from active drug or alcohol use, or from an inability to set longer-term goals. Finally, lack of support or logistical difficulties include fear of disclosure of HIV status, difficult and unstable living conditions, and poor access to transport and to continuous supply of the ARV medications.

The”Barriers to ADH (T8.3) and problem solving (ART) (T8.7)” in *HIV Counseling Tools* lists common barriers to treatment adherence and suggests specific ways of overcoming them. There is also a tool for managing ARV side-effects.

Supporting adherence by drug and alcohol users

ART is rarely emergency treatment; therefore, patients using drugs or alcohol should first be carefully assessed, properly informed and motivated, and have their potential adherence barriers addressed before they start ART.

Drug and alcohol dependency should be assessed and managed. Opioid-dependent patients who participate regularly in *methadone maintenance* treatment programmes have been shown to be more likely to use highly active ART (HAART), and to use it more consistently or with closer adherence. In addition, the following should be facilitated:

- Stabilization of living conditions;
- Management of psychiatric disorders (pre-morbid and HIV-related); and
- Stabilization of serious medical conditions.

The management of prescribed and non-prescribed drug interactions and the adjustment of drug doses require close medical supervision. Dispensing medication in small amounts at frequent intervals will:

- provide opportunities to detect and address adherence problems before they lead to drug resistance; and
- Limit treatment disruption or misuse.

To support and reduce the pill burden among PLHIV, highly effective ARV medicines in combined formed are prescribed once daily as first line regimen again it is important to make sure that drug and alcohol users understand that their use of drugs and alcohol complicates their treatment because of complex drug interactions and effect on liver. Health issues such as poor nutrition and substance-related illnesses may add to this challenge.

You should assess and ensure that the client's drug and alcohol use–the type, frequency, and context of use–is documented and determine if the client has a dependency issue.

Other treatment medications

Complex treatment regimens that include TB, OI, and STI medications, as well as ARVs, will need to be clearly"mapped" for clients. They will need to know what drug to take, when to take it, and what to do if they miss a dose. They will also need instructions on the side-effects of each of these drugs.

Support during ART

The individual should have a follow-up adherence counseling visit within one to two weeks and continuous adherence counseling at regular intervals throughout ART. Adherence barriers can change over time and individual patients will need different levels of support as their life circumstances change and as they become accustomed to their treatment, experience side-effects, feel better or worse, and face new challenges. Adherence support therefore needs to change over time as well. Ongoing adherence counseling and continuing interactive communication are the keys to providing effective adherence support to the patient on ART.

In addition to adherence support, the adherence counsellor or physician should perform *adherence monitoring and assessment*. Adherence should be assessed on a basic level by all members of the multidisciplinary team at all counseling visits.

A typical follow-up counseling session involves:

- Reviewing the treatment experience of the client;
- Assessing any need for referral back to the doctor (usually related to side effects):
- Monitoring adherence (over a defined period):
- Reviewing and finding solutions to barriers to adherence;
- Reviewing adherence to transmission risk reduction; and
- Conducting a psychosocial assessment.

Adherence assessment and monitoring

Adherence is difficult to measure, as it cannot be assessed accurately by any single method. Therefore, several approaches are used to assess adherence. Some measures in current use are client self-reporting, electronic monitoring, pill counts, provider estimation, and measurement of medications in the bloodstream. All methods have their strengths and weaknessess; none offer the security of a totally accurate account of the individual's adherence.

Chapter 9

Addressing Special Needs

This chapter addresses the special issues that you may be called upon to address in the course of providing pretest and post-test counseling, adherence counseling, or ongoing psychological support to individuals living with HIV.

Section 1: pregnant women, new mothers, and their partners

HIV can be transmitted from mother to child during pregnancy, delivery, or breast-feeding. Without specific interventions, HIV-infected women will pass the virus to their infants during pregnancy or delivery in about 15%-25% of cases, and an additional 5%-20% of infants may acquire postnatal infection during breast-feeding, for an overall risk of 30%-45%. But this means that almost one-third of children born to HIV-positive women will be infected with HIV.

Reducing HIV transmission from HIV-infected pregnant women to their infants requires a range of interventions beginning with HIV testing and counseling and including ART for pregnant women or ARV prophylaxis for newborns, early diagnosis of HIV in HIV exposed children, safer obstetric practices, and counseling and support for safer infant feeding.

Ideally, all women and their male partners should receive HIV testing and counseling before deciding to become parents (refer to"Couple counseling" in chapter 4). And those not tested should be tested during delivery and even in post-natal period.

HIV testing in pregnant women

Routine testing during antenatal care is an important way to reach women with information about HIV and AIDS, to identify women with HIV so that they can gain access to services and participate in interventions to prevent MTCT, and to prevent infection in women without HIV.

It is important to provide essential HIV and AIDS information at the first antenatal care contact, to be sure that as many women as possible receive the information and are routinely offered HIV testing. This can be done through a group information flipchart and through key pretest information from the individual provider seeking informed consent for the HIV test.

The advantages of HIV testing should be explained. Women must understand that there are clear advantages to being tested for HIV. Pretest counseling and group information sessions should address HIV transmission and the risks associated with MTCT during pregnancy, birth and breast-feeding.

Retesting in the third trimester

If the woman is considered to be at high-risk of HIV transmission, she should be retested in third trimester if not tested positive earlier.

Managing women who decline

If a woman refuses to get tested, spend extra time with her to find out why she refuses and see if you can help her with any problems that keep her from accepting testing.

Refer to chapter 4 for counseling pregnant women.

Some women may be afraid to get an HIV test, do not want to know their HIV status, or do not want to discuss results with their partner. Stigma and discrimination against pregnant or breast-feeding women who are known to be infected with HIV is a serious problem in many communities. Counseling women about the benefits to themselves and to their infant of knowing their HIV status can usually help to overcome fear of stigma and discrimination, and other barriers.

Allowing women to express their concerns is also important. Fear of negative outcomes is more common than actual negative outcomes for most women; most who disclose their HIV status report positive outcomes, support, and understanding. When counseling, it is important to assist women in evaluating the real chances of adverse outcomes and help them make a plan to minimize those outcomes.

If a woman does not accept HIV testing at her first visit, ask again at each future visit whether she is not ready to be tested. At each clinic visit briefly review the benefits of knowing one's HIV status and emphasize the care that is available to HIV-positive women and their infants to help her decide.

Counseling pregnant women who test positive for HIV

If a pregnant woman tests positive for HIV, counselors should discuss the following:

- the risk of being re-infected and of infecting someone else in attempting to become pregnant;
- the risk of mother-to-child transmission of HIV;
- benefit of early initiation of ART for her own health and to prevent transmission to her un borne child
- options for the prevention of MTCT (FP & RH) refer National Guidelines of HIV in Nepal
- importance of hospital delivery to minimize the risk of transmission to baby, timely performing HIV testing of newly born HIV exposed child, timely initiation of Arv prophylaxis to babies to minimize the risk of HIV

Drug and alcohol using pregnant women who have been diagnosed HIV positive should be advised that that using such substances during pregnancy can be harmful to the baby and can cause birth defects or the baby being born addicted to the substance. Inform the client that it is important to their infant's health that the antenatal care clinic doctor knows that they have HIV and that they are using drugs or alcohol so that the right treatment can be offered to you and your baby. Counselors should not offer advice to the mother to immediately cease using the drugs or alcohol as to do so may actually create serious health problems for the mother and her baby if the mother is substance dependent. Counselors' should refer the mother to an antenatal care clinic and indicate in the referral that the mother is using substances. The counselor should discuss the need to share this information with the doctor and gain the client's consent. The woman should be referred to a physician who can conduct the medical assessment and offer more specific medical advice applicable to her health status.

Encouraging partner testing

In some countries only one of the partners in up to 25% of couples is infected and the other is not (discordance). The partner should be encouraged to have an HIV test. The discordant couple should be told about the risk of HIV transmission in unprotected sexual intercourse and the issue should be explored in a counseling session for the couple. A case example is presented in box 9.1.

A young married HIV-negative woman and her HIV-positive husband visited a clinic today and of their desire to start a family. The husband asked for advice on how to minimize the risk of transmitting HIV to his wife and how to prevent the baby from becoming infected.

In the case example presented in box 9.1, the counselor should discuss the following with the clients:

- HIV transmission between the husband and wife;
- HIV transmission in the womb, during delivery, and during breast-feeding;
- the high viral load during the period when HIV is newly acquired (seroconversion), placing the woman at greater risk of infecting the unborn child;
- an offer to have the woman undergo HIV testing if she has not recently been tested or if the couple have been having unprotected intercourse; and
- Immediately enrolment on ART and remain adhere to treatment and try to conceive baby after 3-6 months of ART
- Motivate by providing undetectable is equal to untransmissiable. If the PLHIV is on ART and VL is undetectable, then HIV transmission via sexual route is not possible
- The HIV negative partner can also be provide Pre-exposure prophylaxis as an option to minimize the risk.
- an offer to have the woman undergo HIV testing if she has not recently been tested or if the couple have been having unprotected intercourse; and
- Referral of the clients to antenatal care physician who can offer the couple specific advice tailored to their needs and health status.

Counseling to prevent mother-to-child transmission

Counseling should address the three primary transmission risk strategies that can be employed to reduce mother-to-child transmission:

- early initiation of ART and adherence to ART to minimize the rate of transmission
- safe obstetric practices; delivery to be done in health institution and.
- Infant-feeding options and support. Exclusively breastfeeding for first 6 months of age to the HIV exposed child and after 6 months provide complimentary feeding until the child becomes 2 years of age

ART for pregnant women refer to National testing and treatment guideline

Early enrolment on ART is required to reduce the risk of HIV transmission among new born. The counselor must be able to provide information on risk versus benefits of ARV medicines on the pregnancy and its outcomes. To support adherence to the newly diagnosed pregnant women including spouse or supportive other family members can be done after taking consent from the pregnant PLHIV woman. The ART for mother started on same day after ruling out other underlying opportunistic infection and proper on possible side effects and its management to be done. The pregnant mother should be provided information on requirement of frequent ANC visit, ARV refill visit and hospital delivery to decrease the risk of HIV transmission to new born by providing ARV prophylaxis to child after born and TNA PCR testing requirement to know the HIV status of the child and follow up test of baby after stopping breastfeeding is required to be counselled from the day 1 of diagnosis. So that lost to follow up, home delivery and poor adherence to the treatment can be minimized.. The risk of HIV acquisition with PMTCT intervention can be deducted below 2% from 45%. Those who are infected will need continuing medical care, and their mothers and families will need social and emotional support

Counseling on delivery method

It is important that pregnant HIV-positive women understand the benefits of delivering a child within a service that can support safe delivery and minimizes HIV transmission risk. Most infants who

acquire HIV during delivery are infected through exposure to maternal blood or cervical secretions that contain the virus. Prolonged membrane rupture and invasive delivery techniques have been associated with higher risks of MTCT during labor and delivery. Strategies for reducing transmission during labor and delivery include:

- Ensure all HIV positive women delivers baby at health facility
- minimizing invasive procedures and avoiding artificial rupture of membranes and routine episiotomies;
- minimizing the use of forceps and vacuum-assisted deliveries;
- treating any signs of infection;
- managing postpartum haemorrhage and ensuring safe blood transfusions;
- minimizing aggressive suction of the infant's mouth;
- Immediate clamping and cutting the umbilical cord
- Providing an ARV drug, prophylaxis to the new born (HIV exposed children)
- Early Infant Diagnosis – TNA testing. Sample collection of HIV exposed children at birth as per National guidelines
- Providing cotrimoxazole to infant after 6 weeks of birth.
- on providing all immunization (additional measles vaccine at 6 months) following National Immunization protocol

Infant-feeding counseling

All women who are considering pregnancy or already pregnant or breast-feeding should understand that breast-feeding carries a risk of HIV transmission to the child. Women with HIV infection have the virus in both their blood and breast milk. The national guideline recommends exclusive breastfeeding for 6 months of age and after 6 months additional complimentary feeding until 2 years of age. For children below 6 months of age mixed feeding is not recommended. The mother should be on ART with 100 % adherence to minimize the transmission of HIV.

About the breast feeding, always consider local custom, the individual woman's situation, and the risks of replacement feeding (which can include an increased risk of other infections and malnutrition). National guidelines guide on infant feeding choices.

Counselors should provide full facts about the risks and benefit of breast-feeding and be able to discuss alternative infant-feeding options in case of special situation otherwise national guideline recommended 6 weeks of exclusive breastfeeding, and continue breast feeding up to two years with continuation of ARV. If facilities for special counseling on infant-feeding options are available, they should be offered. This special counseling can help a woman make an informed decision about how to feed her infant..

If HIV- positive pregnant women is under ART, there is less chances of MTCT. If HIV-positive women have access to safe, consistent, and affordable breast-feeding alternatives and the means to use them, the risk of death and illness from HIV and other infections can be kept to a minimum. Keep in mind that HIV-positive women may face stigma from their families and communities if they do not breast-feed their infants. If breast-feeding alternatives are not available, the health risk to infants who are not breast-fed is six times greater than the health risk to those who are, so breastfeeding remains the better option.

The risk of MTCT during breastfeeding is greater when an HIV-positive woman does not exclusively breastfeed for the first six months, or if complications develop (e.g., mastitis, cracked and bloody nipples) from poor breast-feeding techniques. The risk of transmission also increases if the mother becomes infected with HIV while breast-feeding. The duration of breast-feeding is also associated

with the level of transmission risk: after six months, the risk of HIV transmission may be greater than the benefits of breast-feeding.

Alternatives to breast feeding

- Exclusive use of commercial infant formula;
- Exclusive use of home-prepared formula (modified animal milk or dried milk powder and evaporated milk);
- Exclusive use of non-modified cow's milk;
- Exclusive use of modified breast milk (mother expresses milk, boils it briefly to kill the virus, then cup-feeds); or

Government regulated breast milk banks, functioning according to WHO/UNICEF

Counseling male partners

Men need information on how to prevent transmission of HIV to their female partners, particularly during their partner's pregnancy and during breast-feeding. In all counseling contexts, especially when men present for HIV tests, counselors should take the opportunity to ask if they have female partners and address HIV prevention strategies to reduce MTCT. Male partners of pregnant women should be explicitly warned about the risk posed to both the mother and the child when they share injecting equipment, or have unprotected sex with other female or male partners during their partner's pregnancy. Men should also be advised to refrain from such behavior while their partner breast-feeds. It is noted that in the Asia and Pacific regions many MSM have female partners of child-bearing age. It is therefore essential that services offering counseling to MSM explicitly address the issue of preventing MTCT.

It is further recognized that it is important to increase the male partner's involvement in antenatal and postnatal care. Partners should be invited to consultations where appropriate and feasible. Innovations such as "new father" clubs can support the effort to reduce MTCT, and improve family relationships. Just as many antenatal care services offer prenatal classes to women, similar classes can be offered to couples or to prospective and new fathers. It is important that men who are diagnosed HIV-positive are offered support in disclosing their status to their partners. The involvement of male partners may necessitate services that have flexible consultation hours and evening information sessions.

Providing emotional support to pregnant women and new mothers

Pregnant women recently diagnosed and those who have deteriorating health are especially vulnerable to depression. Positive women are also at increased risk of postpartum depression. Depression not only reduces the quality of life of infected women but can contribute to poor treatment adherence, and to an inability to bond with, and care for, their newborn baby. It is imperative that counselors are aware of common signs and symptoms of depression; these are discussed in chapter 5. General post-diagnosis care counseling is discussed in chapter 6.

Pregnant women should have access to referral services with 24 hours attention and care and support services.

Postpartum depression

Postpartum depression affects 10%-15% of women who give birth. It is best described as the "baby blues" that deepen and last beyond the first month. Women who suffer from postpartum depression may feel profound sadness, have obsessive thoughts, and be unable to shake troublesome worries. Postpartum depression can be related to hormone changes in pregnancy and after birth and can also be related to psychosocial stressors.

The appearance of postpartum depression varies from woman to woman. It may appear as depression, anxiety, obsessive-compulsiveness, or any combination of these. Women may be suffering from postpartum depression if they feel depressed, lose interest in daily life and activities they used to find pleasurable, and suffer from at least four of the following symptoms almost continuously for at least two weeks:

- extreme fatigue, sluggishness, or exhaustion;
- feelings of hopelessness and helplessness;
- sleeplessness despite exhaustion;
- changes in appetite (loss of appetite, food cravings);
- anxiety, fear, guilt;
- difficulty concentrating;
- difficulty making decisions;
- heart palpitations, tingling, numbness, or feelings of dread, all of which signal a panic attack;
- impulses to harm baby or self;
- disinterest in personal hygiene or appearance;
- obsession with baby's health; and
- Inability to cope with everyday situations.

Postpartum psychosis

Postpartum psychosis is a rare but severe illness that affects one in every thousand women who give birth. A woman with postpartum psychosis may experience delusions, such as thinking her baby is evil, or hallucinations, which involve seeing, hearing, smelling, or otherwise sensing things that are not really there. Postpartum psychosis usually occurs soon after a woman gives birth, within three to 10 days. Postpartum psychotic episodes are generally brief, lasting for at least one day and less than a month. The new mother may experience periods of relatively normal behavior. A psychotic episode that occurs more than a month after a woman gives birth is not considered postpartum, but may be caused by other factors.

Besides experiencing delusions and hallucinations, the woman suffering from postpartum psychosis may also:

- be extremely agitated;
- lose weight quickly without dieting; and
- Go without sleep for more than 48 hours.

Women suspected of having either postpartum depression or postpartum psychosis require specialized medical assistance; counseling alone will not be sufficient. Referrals should be made to either a psychiatrist or an obstetrician or gynaecologist.. If the client refuses to consent to referral and you assess the condition to threaten the life or well-being of the mother or her child then you will need to proceed to make the referral without the consent of the woman. It is important that under this circumstance you the counselor should explain to the woman why you will take this step. Before taking this step you are advised to discuss the situation with your supervisor.

Section 2: children and adolescents

The diagnosis of infants and children is discussed in chapter 1. This section will cover the counseling of children and adolescents as it relates to HIV testing, counseling of parents and guardians, and HIV care counseling issues for children and guardians.

Understanding the counseling context

There is a need for significant scaling-up of access to counseling and testing services for infants and children in order to enable more children to benefit from antiretroviral treatment, care, and support, and thus a better quality of life. Most-at-risk young children and adolescents are unlikely to seek counseling and testing for HIV and are more likely to be counselled and tested. In general, the testing of infants and children occurs in a number of specific circumstances, including:

Children who present in clinical settings with signs and symptoms or medical conditions that could indicate HIV infection including tuberculosis, malnourished children and other OIs, children born to HIV infected women, admitted in orphanage, drug rehabilitation centers.

In cases where the child has been, or could have been, exposed to HIV through:

- mother-to-child transmission;
- sexual activity;
- injecting drug use;
- sexual abuse or rape;
- exposure within a health-care setting (e.g., contaminated needle stick injury or receipt of potentially infectious blood); or
- Living or working on the streets.

Early diagnosis of infants and young children has the following potential advantages:

- early identification, and access of, HIV-infected infants and children to timely and optimal treatment, care, and support;
- access to information and services to prolong life, for example, by improving nutrition and taking exercise;
- easier decision-making regarding infant feeding;
- elimination of anxiety and stress of parents of HIV-negative infants, and among HIV-positive children relief of knowing the truth rather than being worried about the unknown;
- reduction of potential stigma, discrimination, and psychological distress among those diagnosed HIV-negative;
- easier life-planning for parents and children who are HIV-infected; and
- among older children who are HIV-positive, a better understanding of the possibility to live life with HIV with treatment and being able to live life same like others getting education, marrying and further plan for family and do all the job. The importance of preventing further transmission by adhering to treatment practice of safe sexual activities to avoid infecting others.

Paediatric confidentiality

The confidentiality of the child's HIV status should be maintained by the parents, care takers and health care providers. All should work together to disclose the child's status to him/herself according to their age. The study and research has shown that self-disclosure to child should be done before12 years of age. It helps child to gain the trust among family members and health care providers, improve adherence on treatment with their illness and its consequences and make child understand that the quality of life will not reduce due to HIV if treatment is continued as advised by health care providers. The disclosure of child is not one time event so periodic and age specific information should be provided to the child. The undisclosed children may developed fantasies about their illness (worst their reality) feel isolated from source of support and learn HIV status inadvertently. The children needs to know why they take drugs, why they often go to the hospital and in some

situation they often already know diagnosis but they kept the secret wait for adult to tell and do not know where they “caught” the virus.

No person except the child’s parents, other guardians and the treating physician has a need to know the child’s HIV status. The family has no obligation to inform school authorities. If the family chooses to inform school authorities, the child’s right to privacy must be assured.

When disclosing HIV status to children below 12 years:

Use language and concepts appropriate to the child’s age and development stage, use pictures, drawings, and role-plays to explain concepts. Use pictures drawing for the child to express feeling or concerns. Be aware that children may share with other children and may be subjected to discrimination

If service providers have not been sufficiently trained on what information to share and how to communicate it with a child and his (possibly HIV-positive) parent(s) or guardian(s), negative outcomes may include:

- not fully understanding the situation, or only understanding the negative implications;
- disclosing their status without being aware of the possible negative ramifications, such as stigma and discrimination; and
- feelings of anger, resentment, anxiety, hopelessness and depression.

Legal and ethical considerations in testing infants and children

The United Nations Convention on the Rights of the Child (CRC) states that ”States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child’s parents, legal guardians, or family members” and further that ”no child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation”. In the context of HIV testing, every child has a right to have his or her HIV test result kept confidential. The CRC’s General Comment No. 3 states that”States parties must protect the confidentiality of HIV test results, consistent with the obligation to protect the right to privacy of children (art. 16), including within health and social welfare settings, and information on the HIV status of children may not be disclosed to third parties, including parents, without the child’s consent”.

Counselors, along with other health-care providers, must be clear about the national laws and policies on counseling and testing of children, and to whom, when, and how best to inform or disclose a child’s HIV status. HIV testing of infants and children should be supported only when it is in the best interests of the child. The potential benefits and harms associated with the testing of a child should be balanced along with the reasons for the request or suggestion for testing.

Consent and confidentiality. In general, HIV testing should be conducted only after an individual is informed of the benefits and risks and voluntarily agrees to test. Children in general, and those under 10 years in particular, present special circumstances for seeking consent, both of which may be affected by national policies, provider judgment, and the maturity of the child. Although parents and guardians often give consent for medical procedures (including HIV testing) on behalf of their children, a child still has a right to ”participate in decisions affecting his or her life”. Mandatory testing of children should not be undertaken in any circumstances and HIV testing or a child’s HIV status must not be used to deny access to education, health care, housing, or any other service.

The age at which a child or adolescent may consent to HIV testing without parental or guardian permission varies from country to country. While most have national laws and policies related to

counseling and testing for adults, most laws and policies are unclear or ambiguous and sometimes conflicting about HIV testing of minors, in particular about who is authorized to give informed consent and under what conditions. In some cases, age at which a minor may give consent to test is actually higher than the legal age for which they can consent to sex, consent for marriage, termination of pregnancy, or voting rights. Laws and policies on consent do not often give consenting rights to informational caretakers or medical staff, an issue in terms of HIV testing in case of orphans, abandoned infants, and street children.

Counseling children in association with HIV testing

Counseling must be available for any child undergoing HIV testing, including post-test counseling for the child and the parent(s) or caretaker(s). Counseling children infected or affected by HIV and AIDS requires the following skills:

- assessing maturity for understanding the benefits and risks of testing and for providing consent;
- age-appropriate communication;
- disclosure;
- the process of informing a child of his or her HIV status;
- counseling for adherence to HIV medication;
- ability to talk to children about death;
- assessment of sexual abuse and rape;
- parent or caretaker counseling; and
- Ongoing psychosocial counseling.

Creating a child friendly environment

- You can give an approximate time to the child about how long the session will last.
- If the parents or guardians are not in the room, inform the child exactly where the parents or guardians will be. Small children may need to be shown where the parents or guardians are waiting.
- Be prepared to sit on the floor with a child or talk while you are playing with toys, or even take a walk with the child (where appropriate and safe to do so).
- Discuss confidentiality and its limitations.
- The child or adolescent is informed that this is “a safe place”, a place where the child can relax, talk, and play. The rule is that the counselor cannot hurt the child, and the child cannot hurt the counselor.
- Focus on the child or adolescent. Show an interest in his or her life and daily activities. Be curious. Appreciate who he or she is. Find the uniqueness in each child. Find out what is interesting or special about each child that you see.
- Have toys and objects that the child likes and that are age appropriate. Have toys and objects that will help you illustrate your discussion about HIV and what will happen during an HIV test.
- Use age appropriate language.
- Be calm and unhurried. Follow the child’s lead. Listen to what he or she wants to talk about and encourage it, as long as it is not destructive or dangerous. You can bring the child back to the main topic if he or she is not talking about it or showing it in his or her play.

Should children be told they have HIV?

The National Disclosure guidelines to support for disclosing HIV status to the children. The time of disclosing child depends on the family, care takers, age and developmental status of children.

Different countries have different age specific recommendations, but according to child development status it is wise to begin partial disclosure from the age of 5-6 and reach full disclosure before 12 years of age. If this is not achieved, then the teenager can be difficult to handle and get his trust towards all involved in his/her care including health care workers. There are four phases of disclosure:

1. Identify the children who can be disclosed in the respective ART centers
2. Plan with family members/care takers and children on readiness and prepare for the disclosure
3. Follow all the steps of during the disclosure
4. After disclosure monitoring and evaluating the status of children and family member

. Informing a child about his or her HIV infection is a process, not a single event, that moves along as the child's understanding evolves with age.

When informing a child of his or her HIV or health status

- use age-appropriate or developmentally appropriate language and concepts that the child can understand;
- ask the child what he or she is thinking and what he or she knows about HIV and AIDS;
- use words, pictures, and drawings to explain HIV; and
- ask the child if he or she has questions, and answer them honestly and directly.

Non-disclosure may lead to gap in conversation among child and family members, as they would not be able to answer many queries raised by the child, non- adherence to the treatment (as child do not know medicines are important to be healthy), the teenagers could already be sexually active, and so risk behaviors could not be decreased timely, anxiety, fear, and depression and also deprives the child of support and referral to psychosocial support and activities.

Behavior change and adolescents

Behavior change during adolescence is often strongly influenced by peers. It is important to assess the level of pressure your client experiences and discuss this with him or her. Consider evaluating the client's readiness for change and employ motivational interview strategies (discussed in chapter 3). Also taking into account the client's readiness for change, determine what skills training should be provided in strategies for managing peer pressure. Further reading recommendations are offered at the end of this handbook.

Preparing children and adolescents for hospital visits and medical procedures

Sometimes parents and guardians are uncomfortable telling their child about going to a clinic or the hospital. Parents might feel protective or anxious about their child's reaction. Parents or guardians should be advised by the counselor that "You can protect your child from the information but you cannot protect him or her from the experience". At the very least, it is important that the child knows that he or she is actually going to a clinic or the hospital. It can also be helpful if the child knows the reason(s) why (e.g., an outpatient check-up or assessment or an inpatient medical procedure, operation, or treatment).

The child/adolescent should be provided with some basic information about what will happen at the clinic or hospital.

The child's or adolescent's level of development determines the approach.

Young infants (newborn through eight months). When the baby is going to hospital or having an operation, it is normal for parents to find it more stressful. Young infants usually separate easily and can be comforted quickly by the care staff in the hospital. Parents or care takers should be advised

of this by the counselor. Often parents or care takers can provide a familiar rug or soft toy so that the child can derive comfort from this. Where a drug- or alcohol-dependent mother has delivered a child who is showing signs of withdrawal the mother will require support and counseling in relation to feelings of guilt and distress with the fact that the infant needs specialist drugs for withdrawal treatment.

Older infants and toddlers (from eight months through two years). Most children in this age group will have some difficulty separating from their parents, and older infants can initially behave poorly with care staff. The parent knows the child best and can tell the nurses and doctors how the child might react and what can be done to help the child cope better. Parents are advised that they could start telling their toddler about going to the clinic or hospital a day or two before.

Often the parents of most-at-risk adolescents (MARA) will have limited ability to negotiate with hospital staff. Counselors can therefore provide support to parents in communicating with hospital staff and managing administrative procedures. This may be particularly important where parents are drug users or sex workers and have had poor experiences navigating the health system and dealing with health professionals.

Preschool and young school-age children (three through six years). Most children in this age group can understand simple explanations about their illness and may need time to express their feelings, draw or play, and ask questions. Parents and guardians could start telling their child a few days to a week before. Playing games like nurses or doctors with dolls, etc., can be helpful. The child especially could role-play the actions of the doctor or nurse and give the ”child” an injection. Counselor can provide a syringe without a needle for this purpose and work with parents and guardians to help them prepare the child.

Older school-age children (seven through to 11 years). Most children in this age group are able to understand the reason for a hospital stay and what is going to happen to them. Children at this age may have fears about waking up during medical procedures or operations, and about pain and changes in their body. Plenty of reassurance, talking time and play-practice on teddy bears or other toys, and drawing can help. You could start telling and preparing the child a week or more before. Children who have been living on the streets and who normally project a “streetwise” demeanor may regress to quite dependent and fearful behavior. Having treatment support buddies or other supportive care givers visit will assist the child in adjusting to this environment.

Adolescents (12 to 17 years). Most adolescents have a good understanding of what is going on in their bodies and the reason for clinical or hospital visits. Including them in discussions or decisions about their care and treatment can increase their sense of control and reduce anxiety. Adolescents often have several worries about clinical visits or going to hospital. They may be concerned about the impact of an illness or medical procedure on their appearance, the reactions of friends, independence and privacy, or sexuality issues. Also, be prepared to discuss the adolescent’s fears about dying or disability. The adolescent may need time to think about it, gather information and read, discuss it with you in more detail, talk to other teenagers with HIV, and make plans to be absent from school, work, and social life. Counselor are advised to discuss this issue with parents and guardians. It is best to start telling and preparing the adolescent a few weeks in advance.

When adolescents are unaccompanied minors they should be encouraged to develop links with peer support groups before hospitalization. In some circumstances hospital buddy support systems can be developed so that the adolescent will have the opportunity to have visitors and support while in hospital.

Helping parents or caregivers talk about the hospitalization

Often a parent can feel nervous about what to say to the child. The counselor could practice with the parent to increase his or her confidence. Also, role-playing can be a good way to troubleshoot for those unexpected questions and reactions. In many circumstances you will be dealing with a family where the child or adolescent has left home or regularly come and gone. Often there will be family resentments.

Brothers and sisters. If the child has brothers or sisters, the other children may also need explanations, reassurance, and an opportunity to express their feelings. The counselor's role may be to offer clarification and support.

Grandparents. Grandparents are often closely attached to their grandchildren and can be a very important part of the child's life. Involving grandparents (or other members of the child's extended family) in the preparation and hospital stay can be a big help to the child. This can let your child avail himself or herself of multiple social support and provide a sense of normality.

Talking about medical procedures with younger children

It is most helpful to talk to the child in simple, clear language with words that you know he/she understands:

- "special pictures" could mean X-rays or scans;
- "special medicine or drink" could refer to medication or tonics; and
- "special creams" could be cream-based medications.

Counselors can be a great help to the parents, nurses, and medical staff by finding more child-friendly ways to explain other common hospital words such as ”injections”, ”drips”, ”plaster”, ”bandages”, ” dressings”, or ”monitors”.

Giving information about the hospital or clinic in advance

After you or the parents/guardians have gathered information, you may need to spend time talking to the child about the hospital or clinic itself to”desensitize” the child. You could try some of the following ideas:

- Describe the hospital or clinic (e.g., a place/big building or house with many children in it). An advance visit to the hospital or clinic might help.
- Tell the child or adolescent about the people who work in the hospital or clinic (e.g., doctors are men and women who help children who are sick). It is useful to have a child-friendly sentence prepared to describe the other staff your child might meet such as the nurse or laboratory technician.
- Talk about what hospital or clinic staff might look like (e.g., the differently coloured uniforms, tissue hats in the operating theatre, name badges).
- Talk about what the hospital ward may be like (e.g., a big room with many smaller rooms with children of all ages in them, or the daily routine). Also, explain that your child might have to share or change rooms with other children while in the hospital or clinic. This can prevent problems of non-compliance and resistance.
- Talk about what the food may be like.

Giving the child a personal reason for the hospital visit or medical procedure can motivate him or her to comply with treatments and help your child make sense out of the experience (e.g., being able to run longer without getting tired, wearing special garments so legs will look better). The reason would depend on the illness or health problem being treated and your child's level of understanding. Tell parents or carers that ”It is important to encourage the child to talk about the hospital or clinic and

his or her ability to cope with it".

Statements of dislike for the hospital made by counselors, parents, or a guardian to a child are often unhelpful.

Parents should be advised that in general it is best to answer all questions even if this means saying, "I don't know but I will find out". Try to remember to come back later with the answer! Even if it is difficult for you, try to answer questions openly and honestly. Parents should be advised that reassurance is vital. Parents should reassure the child that they and other members of the family will visit as often as possible. The reassurance that the family will be there can help the child cope better and separate easier during absences. Sometimes children's hospitals have some form of parents' accommodation so that parents can arrange to stay overnight. Telling the child that you will be doing this can also be reassuring. Parents are advised to try to stay calm; their child may pick up on their own level of fear and concern, and be frightened by this.

Counseling in relation to pain management

Dealing with pain can be difficult for parents and children. Pain can be a feared experience associated with hospital and medical procedures. Parents and caregivers should be advised that if their child asks if a medical procedure hurts, telling the child or adolescent that it will not hurt when it does hurt is not helpful. This false reassurance tends to diminish trust, increase anticipatory fear, and reduce compliance. Often children and adolescents can tolerate more pain when prepared for it, know what to expect, have words to describe it, and are reassured in advance about ways of coping with the pain. Breathing techniques to " blow away the pain" can be taught to the child or adolescent by a parent or the counselor. Being prepared for the experience of pain can also improve the child's sense of pain control. In addition to medical treatments, most hospitals and clinics should offer support for pain management. Children may find it hard to describe pain and so they will need assistance. Smiling and sad faces can help children express how bad the pain is.

©©	©	©	©	©©
No Pain	Feel better	Not sure	Pain not Strong	Very strong pain

Alternatively, a picture of the body can be provided and children can draw, or point to, the parts where the pain is.

Section 3: men who have sex with Men

Who are MSM?

The term men who have sex with men (MSM) is meant to address all men who have sex with men, regardless of their sexual identity. It is used because only a minority of men involved in same-sex behavior define themselves as gay, bisexual, or homosexual but may more aptly self-identify using local social and sexual identities and behaviors. They do not consider their sexual encounters with other men in terms of sexual identity or orientation. Many men who have sex with men consider themselves to be heterosexual rather than homosexual or bisexual, especially if they also have sex with women, are married, take the penetrative role only in anal sex, or have sex with men for money or convenience.

Broadly all the people can be categorized into different forms according to their sexual orientation, sexual identities and sexual behavior.

Sexual orientations: Sexual orientation of an individual is determined by the fact to whom the individual is sexually attracted. It may be 100 percent to opposites sex or 100 percent to same sex or more or less to both the sexes.

Sexual identities: Sexual identity is determined by the fact how a person identifies himself or herself, the person may identify himself or herself as homo-sexual, hetero-sexual or bi-sexual.

Sexual behavior: Sexual behavior answer the question who do the person have sexual contact with, it may 100 percent with opposite sex or 100 percent with the same sex or may have sexual contact with both the sexes.

A person who is sexually attracted to opposite sex may have sexual contact with the same sex due to certain circumstances. Person identifying himself as homosexual may not have the sexual behavior of homosexual person. Similarly the term MSM includes various categories of men who may be distinguished according to the interplay of variables such as:

- sexual identities, regardless of sexual behavior (gay, homosexual, heterosexual, bisexual, and transgender, or their equivalents, and other identities);
- acceptance of, and openness about, their non-mainstream sexual identities (open or closeted);
- sexual partners (male, female, or transgender);
- reasons for having these sexual partners (natural preference, coercion or pressure, commercial motivation, convenience or recreation, or life in an all-male environment);
- roles in specific sexual practices (penetrative, receptive, or both); and
- gender-related identities, roles, and behavior (male or female, masculine or feminine/effeminate, cross-dressing, or gender-concordant dressing).

What do counselors need to know about sexual identity and sexual behavior?

”Men who have sex with men” has become a popular term in the context of HIV and AIDS, where it is used because it addresses behaviors that put men at risk of infection. It has been argued that the term is too focused on sexual behavior and not enough on other aspects, such as emotions, relationships, and sexual identity. Some organizations and individuals prefer the term males who have sex with males because it indicates a broader group of individuals engaged in sex with members of the same sex. In particular, it does not have the age limitation implied by the term ”men”, and therefore includes boys who are having sex with each other and also sexual relationships between men and boys.

In part the term MSM can be seen as a reaction to the language that has developed in Western cultures to describe or ”medicalize” sexual acts between men. Also, the emergence of the ”gay culture” in Western societies during the 20th century has encouraged the belief that people are either ”gay” (homosexual) or ”straight” (heterosexual). This may be true for some people in some parts of the world, but for many men, having sex with other men is just one part of their sexual life and does not determine their social or sexual identity. Some MSM may be highly visible in the community and can include men who dress as women or wear some items of women’s clothing. However, other MSM may be completely indistinguishable from non-MSM. Where”homosexuality” is not visible it is sometimes thought not to exist; however, this is probably not the case. In fact, sex between men happens in most, if not all, societies. Public discourse that denies the existence of same-sex activity does not reflect what happens in real life.

Possibly the largest group of MSM in most countries in Asia is that of men who do not accept their non-mainstream sexual behavior, do not openly self-identify as gay or homosexual, and who have either casual and anonymous sexual encounters or highly clandestine relationships with other men. Some of these men may be married or also have sex with women. A few may self-identify as

bisexual. Some men who self-identify as heterosexual or bisexual occasionally have sex with men for pleasure, usually because women are less accessible. Some men may have sex mainly with transgender MSM without self-identifying as gay or homosexual, primarily because transgender MSM are not considered men in their cultural context.

There are men whose natural preference is for women but who have sex with men because of restricted access to women. This can happen in conservative societies that encourage strict social segregation of men and women, or in all-male environments over extended periods of time, such as prisons, military establishments, male migrant labour settings, and all-male educational institutions. Denied access to women, men have to gratify their sexual urges with other men, without self-identifying as gay or homosexual. Many male sex workers across Asia often self-identify as heterosexual and have sex with men mainly to support themselves and their families. They are often married or have girlfriends or female sex partners. There are, however, some male sex workers who do self-identify as gay or homosexual and have sex only with men. Some men prefer to have sex only with men but pressure to get married and start families results in their having sex with women. Some have a preference for men but are not averse to women, and vice versa. Others prefer to have sex only with women but end up having sex with men for money or because they have no access to women. The ambivalent position of male-to-female transgender individuals adds other dimensions to the scenario.

Why do some men engage in same-sex behavior?

It is not known why, while most people are sexually attracted to the opposite sex, others are attracted to the same sex. Some theories stress biological differences between heterosexual and homosexual adults, suggesting that people are born with their sexuality predetermined. Though experiments and tests have been undertaken to measure differences in hormone levels, genetic make-up, and brain structures of homosexual and heterosexual people, the findings have, for the most part, been unclear. One psychological explanation stresses the importance of life experiences, childhood, and relationships with other people, particularly with parents. A person's assumptions about sexuality and that person's behavior are influenced by family environment, experiences, and sense of self. Beliefs about sex are initially shaped by family values. Later on these beliefs may be challenged and shaped by pleasant and unpleasant sexual experiences, which also shape their choice of sexual activities and partners. Throughout life a person's sense of who and what he is has a strong impact on sexual development and experience. Another theory suggests that preferring your own sex is a matter of willpower, and that a man who has sex with men does so out of a wish to deviate from established gender roles. However, there is little evidence for either of these theories. Other researchers think that it may be possible that sexual orientation is a mixture of both biology (nature) and social conditioning (nurture).

Key counseling issues and tasks

Although many of the issues surrounding HIV are similar for MSM and for the rest of the population, other issues may arise during counseling. These are discussed below.

Beliefs about masculinity. Healthy and strong men do not get sick or cannot get infected. Such beliefs may be supported by previous experiences of not using a condom. It is important that you acknowledge the difficulties the client experiences with these issues and challenge these beliefs. This indicates to the client that, even if strong and healthy, he is susceptible to HIV and other infections if he does not protect himself.

Diagnosis and treatment of STI. Ideally, counselors should recognize the genital, oral, or anal symptoms of STI that may be disclosed by the client during the HIV risk assessment. When STI is suspected, clients need to be referred to a properly equipped laboratory for diagnosis and treatment. Doctors and other medical staff must be trained to identify and treat infections of the mouth and anus, as well as the sexual organs.

Internalized homophobia. This is present when a client feels uncomfortable about his sexual identity and sexual behavior. When the client is unwilling to admit to same-sex behavior and is therefore unwilling to take protective measures, it is important that you explore the reasons for the discomfort and unwillingness to have protection. Clients who have significant difficulties with their sexuality may find it beneficial to see a counselor or to review some of the information for clients available on the websites or in the references provided at the end of this handbook.

Poverty. Poverty renders some unable to practice safer sex because of the cost of condoms and appropriate lubricant. Also, because of poverty the need for financial reward can take precedence when a paying partner refuses to use prevention or offers a higher payment for unprotected sex.

Safer-sex strategies. Clients need to gain knowledge and skills in safer-sex strategies specific to male-to-male behavior.

Sexual dysfunction. Issues of sexual identity, fear of infection, or HIV status may prevent the client or his partner from maintaining an erection, affecting the ability to use condoms. Similarly men may experience difficulties reaching sexual climax (retarded ejaculation) and typically respond by removing the condom or avoiding the use of condoms in the first place to maximize stimulation. It is important that you normalize the possibility of these difficulties by saying, ”Many men I see report that they have difficulties maintaining an erection or reaching sexual climax and this often results in their not being to use a condom.... Do you experience any of these difficulties?” If the client informs you of these difficulties you can suggest alternative sexual practices or ways to increase stimulation while the condom is in place. A referral to a doctor who can assist the client can also be made. Often sex-worker peer counselor or educators can assist in these situations.

Sexual violence. More men than we would like to believe are victims of rape or coercive sex. This is seldom discussed out of fear of emasculation. If sexual violence is disclosed or suspected then sexual assault protocols should be followed.

Suicidal thoughts. MSM are at higher risk of suicide because of the double stigma from same-sex behavior and HIV-positive status. If the client discloses thoughts about suicide, protocols in suicide risk assessment should be followed. All MSM and especially those who indicate that they are having difficulties accepting their sexuality or forming relationships, who experience rejection by partner or family, or who use significant quantities of drugs and alcohol may be at heightened risk of suicide.

Risk reduction counseling among MSM with female partners

When men present for HIV testing they may not volunteer their sexual identity. When conducting a risk assessment it is best to first of all remind the client that the interview is confidential. Then ask them: ” When you have sex, do you have sex with men, women or both?” Asking a client if he is heterosexual, homosexual, or bisexual is asking about sexual identity rather than sexual practice. It is also important to understand that men who self-identify as homosexual may not disclose that they also have sexual relationships with women unless explicitly asked. If you only ask questions related to sexual identity you may miss discussing specific exposure risks.

Men who are in relationships with female partners but engage in sexual activities with male partners and who cannot introduce the use of condoms into their heterosexual relationships should be advised

to have regular HIV tests and to use condoms with male partners.

The risks associated with MTCT should also be discussed with men who have female partners. During HIV counseling associated with HIV testing, men who have indicated that they are at risk of HIV infection or who test positive should consider how they can reduce the chances of infecting their female partners. Furthermore, you should ask if the partner is pregnant, and if they answer yes, then the men should be offered advice on preventing unplanned pregnancy, as well as referral for family planning. It should be emphasized to them that condoms can not only reduce HIV and STI transmission but also prevent unplanned pregnancies. Men who test positive should be offered support in disclosing their HIV status to their partners, even if they do not wish to fully acknowledge the fact that they contracted HIV through same-sex behavior. Partner disclosure strategies are discussed in chapter 7.

All men, irrespective of their status, should be warned explicitly about the risks of transmitting HIV through unprotected sex while their partner is breast-feeding.

To understand more about counseling MSM it is important that you go over the materials cited as references at the end of this handbook.

Section 4: transgender and intersex clients

Understanding the terminology

Transgender is a broad term that designates somebody who does not fit clearly into ”male and female” descriptions. The individual rejects the gender assigned to him or her at birth. Transgender is sometimes referred to as gender variant.

The term transsexual refers to an individual who feels that his or her gender identity does not match the biological body he or she was born with or the gender he or she was assigned by society. Transsexuals can be referred to as male-to-female (MTF) or female-to-male (FTM). Transsexuals are further described in terms of whether they are ”pre-operative” (”pre-op”) or ”post-operative” (”post-op”). Some describe themselves as ”no-operative”(”no-op”).

Cross-dressing refers to the act of dressing in the clothing typically worn by the opposite gender and may be used in reference to both transsexuals and cross dressers. ”Cross-dressers” (also known as transvestites) is a term usually reserved for individuals who like to cross-dress but who do not experience any discord between their physiological appearance and their gender identity. Most cross-dressers are heterosexual men who cross-dress for amusement, role-playing, stress relief, or sexual gratification. Usually biological women are not called cross-dressers, as society allows women a broader range of dressing behavior (women can wear pants, have short hair, etc.).

Other terms used refer either to how society perceives the individual or to the gender reassignment. Passing refers to the degree to which an individual of one gender is perceived (by others in society) to be of the opposing gender. Transitioning commonly refers to the process of moving from one gender to the opposite one. Transitioning is likened to a developmental process that involves many steps.

Increasingly you may hear the term intersex. This term tends to be used by health professionals working in gender orientation. A variety of conditions that leads to atypical development of physical sex characteristics are collectively referred to as intersex conditions. These conditions can involve abnormalities of the external genitals, internal reproductive organs, sex chromosomes, or sex-related hormones. Some of these abnormalities are as follows:

- external genitals that cannot be easily classified as male or female;
- incomplete or unusual development of the internal reproductive organs;
- inconsistency between the external genitals and the internal reproductive organs;
- abnormalities of the sex chromosomes;
- abnormal development of the testes or ovaries;
- over- or underproduction of sex-related hormones; or
- Inability of the body to respond normally to sex-related hormones.

Intersex conditions are not always accurately diagnosed, experts sometimes disagree on exactly what qualifies as an intersex condition, and government agencies do not collect statistics about intersex individuals. Some experts estimate that as many as one in every 1,500 babies is born with genitals that cannot easily be classified as male or female.

What happens when an intersex condition is discovered later in life?

Babies born with these conditions are generally assigned to the sex consistent with their genitals, just like other babies. Their intersex conditions may become apparent only later in life, often around the time of puberty.

Delayed or absent signs of puberty may be the first indication that an intersex condition exists. For example, complete androgen insensitivity may first become apparent when a girl does not menstruate. Medical treatment is sometimes necessary to help development proceed as normally as possible; for some conditions, surgical treatment may be recommended. Many intersex conditions discovered late in life are associated with infertility or with reduced fertility. The discovery of an intersex condition in adolescence can be extremely distressing for the adolescent and his or her parents, and can result in feelings of shame, anger, or depression. Referral to an experienced mental health professional can be very helpful in dealing with these challenging issues and feelings.

Sexuality of intersex individuals

Most people with intersex conditions grow up to be heterosexual, but persons with some specific intersex conditions seem to have an increased likelihood of growing up to be gay, lesbian, or bisexual adults.

Challenges faced by transgender individuals, people affected by intersex conditions, and their families

Intersex conditions, whether discovered at birth or later in life, can be very challenging for the affected persons and their families. Medical information about intersex conditions and their implications is not always easy to understand. Persons with intersex conditions and their families may also experience feelings of shame, isolation, anger, or depression.

Parents of transgender children or of children affected by intersex conditions sometimes wonder how much they should tell their children about their condition, and at what age. Experts recommend that parents and care providers tell children with intersex conditions about their condition throughout their lives in an age-appropriate manner. Experienced mental health professionals can help parents decide what information is age-appropriate and how best to share it. Peer support groups may be available to assist individuals and their families.

Being supportive of transgender and intersex clients?

- Educate yourself about the specific intersex condition of the client.
- Be aware of your own attitudes about issues of sex, gender, and disability.

- Learn how to talk about issues of sex and sexuality in an age-appropriate manner.
- Note that most persons with intersex conditions are happy with the sex to which they have been assigned. Do not assume that gender-atypical behavior by an intersex person reflects an incorrect sex assignment.
- Work to ensure that people with intersex conditions are not teased, harassed, or subjected to discrimination.

Offering counseling on specific risk reduction strategies

While all people are at risk of contracting the HIV virus regardless of age, gender, or sexuality, people with gender issues may face unique risks that the general prevention literature fails to address. It is important for counselors to be aware of these and be able to offer specific risk reduction interventions. Below are some precautions that may have particular relevance to transgender and intersex clients.

Rectal douching or neo-vagina douching. Clients who have a neo-vagina (created through surgery) or a natural vagina or engage in receptive anal intercourse may practice douching to keep these passages clean. They should be informed that douching weakens the lining of the anal passage or vagina and removes friendly bacteria and mucous, exposing the porous membranes (surface skin lining) and increasing the risk of HIV transmission. The practice of douching is generally discouraged by health workers. Clients should be reminded that douching and gels are not an alternative to safe sex, and that only condoms can offer protection from the HIV virus and other sexually transmissible infections during intercourse. If clients should douche because they are concerned about vaginal odours, they should see a doctor as these odours may indicate an infection.

Advice on precautions after gender reassignment surgery. If clients are thinking of, or have recently undergone, gender reassignment surgery involving areas of their body that may be exposed to body fluids during sex, then they should be sure to cover the area until it is completely healed.

Water-based lubrication and neo-vaginas. Although a neo-vagina may produce some lubrication during intercourse it may not be enough for comfortable sexual activity. You should counsel clients regarding the use of water-based lubricants such as ”Wet Stuff” and ”KY Jelly”. These will help avoid breaks or tears in the vaginal lining, which occur naturally during intercourse but which also increase the risk of the virus being transmitted.

Hair removal. Your clients should be advised that when they shave or wax the body or pubic hair they must be careful not to cut or scrape the skin. They should be advised to cover any cuts and abrasions before sex and never allow anyone’s body fluids (blood, semen, or vaginal fluids) to touch damaged skin. They should be especially careful if they shave their pubic hair, legs, chest, or armpits and then engage in ”trick sex” (intercourse between closed thighs or under armpits, etc.).

Needles. Some people may use syringes/needles for hormone injections. HIV and other dangerous viruses including hepatitis can be found in a shared needle or syringe. If your clients inject their own hormones or help friends with theirs, they should be advised to keep a clean supply and never share needles or syringes.

Taping, strapping, and tucking. Taping, strapping, or tucking the genitals could create a warm, moist area leading to skin disorders, chafing, and dermatitis. Removing tape roughly could result in damaged or broken skin. Any of these will increase the risk of the virus penetrating skin during sex. Clients should generally be advised to remove tape carefully and remove any traces of adhesive with something gentle and soothing oil.

Section 5: male, female, and transgender sex workers

Who are sex workers?

The term sex workers encompasses a diverse group of people, so it is therefore difficult to generalize about their behaviors and attitudes towards HIV prevention and care. For example, they may be injecting drug users, married women or men, indentured workers (coerced into sex work and even taken to other countries), college students, or unattached minors. Sex workers may be of all genders (male, female, or transgender). By definition sex workers are any who exchange sex for money and / or goods. They may work temporarily as sex workers or full-time. Effective HTC interventions need to recognize these individuals not only as sex workers but as partners, wives or husbands, and parents.

Sex workers and HIV risk

Sex workers are especially vulnerable to HIV transmission because of their large number of sexual partners and often-high rates of other STIs. Sex workers often feel disempowered to negotiate safer-sex practices with clients on whom they rely for income. In some cases, sex workers may accept a higher price with a client who refuses to use a condom.

Research in some countries has shown that sex workers differ in how they negotiate safer sex, depending on the extent of the emotional relationship. With new clients sex workers may use condoms; with their regular clients or ”lovers”, with whom they have developed an emotional relationship, they do not think about using a condom. In some situations, the risks from injecting drug use and commercial sex work overlap. Prevention strategies from two separate disciplines–harm reduction for injecting drug users (PWID) and reduction of sexual transmission–must then be simultaneously implemented in recognition of the two sources of risk among this population. Sex workers have particular needs, and HTC and psychosocial interventions should be tailored specifically to ensure effectiveness. It is crucial that HTC services reach this vulnerable population, both to protect the sex workers from HIV and other STI infections and to prevent transmission to their clients and partners.

HIV prevention counseling for sex workers

Sex workers or their clients may not be aware on the risks of acquiring HIV and STD during sexual contact. Counselors should be careful to fully explore the sex worker’s understanding of HIV transmission in relationship to a wide range of sexual practices:

- Sex workers may need money urgently for pressing needs, leading them to neglect sexual health considerations.
- Clients of sex workers may be drunk or may not care about their own sexual health or that of others. Counselors should assess the sex workers’ drug and alcohol use. It can be helpful to acknowledge that sex workers often use drugs and alcohol to help them cope with their work. Where sex workers will not abstain from such use, counselors can work with them to identify safe or reasonable levels of use, e.g., ”I can still think clearly with only one glass of beer.”
- Clients may offer more money for unprotected sex.
- Non-penetrative sex or other safe practices may be taboo.
- Condoms and lubricant may not be available at that time
- Some sex workers may work informally or alone, and cannot benefit from the expertise of others or from opportunities to build safe sex into the structure of a more professional transaction.
- Sex business managers may encourage unprotected sex in the belief that this may be more profitable.
- Sex workers cannot keep adequate supplies of condoms and lubricant because they might be viewed as evidence of illegal activities, or because there is nowhere to store them.

- Some sex workers negotiate from a disadvantaged position; for example, negotiations take place in the street or in a place controlled by the client, limiting the ability of the sex worker to negotiate safer-sex practices.
- There may be intense competition between sex workers for clients, making demands for unprotected sex more likely to be met.
- Sex workers may not have adequate negotiation skills, or may not speak the same language as clients. They may be much younger or from a lower class than clients. Female sex workers may be reluctant to talk about sex because of cultural restrictions.

Counseling to prevent transmission can cover a range of strategies and activities to convey information and behavior-change messages. The objective is to provide the sex workers with knowledge about HIV transmission and ways of reducing the risk of transmission, for example, safer-sex practices, the use of male or female condoms and lubricants, symptoms of STIs, and information to clarify misunderstandings about unsafe traditional practices or beliefs. Furthermore, counseling can play an important role in developing the communication and negotiation skills of the sex workers to enable them to negotiate safer-sex practices successfully with:

- clients;
- partners and other people with whom they have a personal relationship; and
- establishment owners.

In particular, the key behavior-change message that must be conveyed pertains to consistent condom use. We have noted that condom use differs among the different type of clients or relationships of a sex worker. Some have argued that relationships other than a sex worker's professional relationships may be as risky or even more risky for HIV and STI transmission. This is because they have less control and less negotiation possibilities. There is emotional involvement as the relationship becomes more than just a commercial arrangement and sex workers will put aside their professional attitudes and control. Counseling therefore needs to address the needs of the sex worker holistically, rather than focusing solely on professional sex work activities.

Motivating sex workers to reduce risk

The professional sex worker has a vested interest in working safely because his or her income depends on staying healthy. Counselors can remind clients of the difficulties they may have if they have sore or painful infections or smelly discharge and require time off work.

Unlike private sex, commercial sexual transactions usually involve negotiating price and other arrangements, providing an ideal time to specify that all services will be carried out in a risk-reducing manner (e.g., using condoms). Sex workers often work in groups, and this means that they can be targeted by health promotion strategies and may be able to agree to encourage and implement safer-sex practices among themselves. Outreach workers can bring clients to an HTC service, where discussion can be facilitated by both a counselor and a peer educator.

Some key prevention interventions with sex workers

Teaching sex workers to recognize visible symptoms of STIs is important. Photographs can be helpful. They should depict conditions that sex workers are most likely to see rather than pictures of more-extreme symptoms. Of course, it must be stressed that many infections, including HIV and hepatitis, have no visible symptoms.

Advising female sex workers on issues relating to sex, menstruation, and contraception. Some sex workers would prefer not to work during menstruation, but many have no choice. Some women use

small sponges to control the flow of blood. These should be taken out and rinsed at appropriate intervals. Sex workers should be reminded, however, that they must use condoms during menstruation and not rely on sponges. It is important that women can confidently offer alternatives to vaginal sex during menstruation.

Taking an oral contraceptive (the Pill) or an injectable contraceptive such as Depo Provera(r) throughout the whole menstrual cycle will prevent bleeding. Advice should be taken from a family planning expert, as menstruation should not be avoided for extended periods of time.

Advising against the practice of douching and cleaning. Male, transgender, and female sex workers use a number of personal hygiene methods. Unfortunately, these often include the use of harsh chemicals and detergents, which are not suitable for use in the anus or vagina because they break down the natural protection against infection. The same is true of vaginal drying agents. Both sex workers and their clients need to be made aware of the possibility of tissue damage from these practices, placing them at increased risk of HIV and other STI.

Advising and referring for advice on microbicides and spermicides. Microbicides are chemicals that kill germs or viral material, including those that may cause many sexually transmitted diseases. Spermicides are chemicals designed to kill sperm. Nonoxynol-9 (N9) is the most commonly used spermicide. Research has been carried out to see if it also has a microbicidal effect. So far, research has shown that N9 does not reduce the risk of HIV transmission. Many people have reported that N9 irritates the skin in the anus or vagina; it might therefore increase the risk of HIV transmission. Most services discourage routine use of N9 because its harmful effects may outweigh any benefits.

Key messages about sex-worker transactions with clients

Counselors can discuss the following strategies that sex workers can employ with clients:

- Refuse the client (”No condom, no way”). Although this eliminates risk, it obviously leaves the worker with no money or even in debt if expenses have been prepaid. So it is not the option sex workers want to take or can afford to take. It also may result in an unpleasant scene with the client and possible difficulties with managers or others who influence the situation.
- Discuss the matter with the client.
- Persuade the client. Persuasion can be successful, but only if the sex worker has the opportunity (sometimes others negotiate on behalf of the sex worker), speaks the same language as the client, and has good communication skills, confidence, and information. The client must also be reasonable and sober.
- Suggesting that sex workers offer an alternative service that does not require a condom is a popular strategy. Clients often visit sex workers for sexual experiences that are different from the”usual”. This places sex workers in an ideal position to sell services that are safe as well as interesting to the client, and therefore perhaps generate more income for the worker. Safer-sex activities are those in which no skin is broken and where there is no opportunity for exchange of body fluids. These kinds of activities can be taught by peer educators in both one-to-one and workshop sessions. Some projects among female sex workers in places where women do not speak openly about sex have found ways to discuss these activities with sex workers. For example, peer educators suggest that sex workers develop the skill of putting a condom on a client without his knowledge (perhaps with the mouth) or rubbing the penis between the thighs or moistened hands rather than the vagina or mouth. While these practices avoid the need for negotiation, however, they can make things difficult for the sex worker if the client discovers the deception and is angry about it.

Counseling in association with the HIV test

Providing feedback on the risks associated with potential exposure in the window period is crucial. It is imperative that sex workers understand that they must practice safer sex and avoid sharing injecting equipment (for example) while they are at risk of primary (acute) HIV infection. It is unclear how often sex workers should be offered HIV testing; however, where it is either realistic or affordable sex workers should be encouraged to undergo screening for HIV every three months, especially if they have difficulties employing risk reduction measures.

When HIV-positive test results are provided many health workers will tell sex workers to stop their work and recommend that they do other types of work. This advice, though well intentioned, is rarely feasible. Often sex workers have limited education and work skills training, and have a family to support. While clients can be referred to job skills training or income generation skills, during the immediate post-diagnosis period counselor interventions should focus on providing emotional support and other transmission reduction strategies.

Messages about the need to inform sexual partners of the sex workers' HIV status also need to focus on support for disclosure to regular personal relationship partners (boyfriend, girlfriend, husband, wife), bearing in mind that sometimes a regular partner may also be a "client".

Supporting HIV-positive sex workers

Research indicates that sex workers often have higher-than-average rates of depression and anxiety, and are often subject to physical abuse from clients. Many sex workers experienced sexual and physical abuse. Sex workers may be at significantly greater risk of suicide immediately after diagnosis and as they begin to experience illness and develop changes in their physical appearance that result in unemployment. Drug or alcohol use as a coping measure will further predispose them to suicide or accidental overdose. Careful monitoring of psychological well-being is required, along with assessment and involvement in seeking support for drug and alcohol issues.

The counselor should help the client acquire all the services necessary. It is also important to review the potential barriers that sex work may pose to treatment adherence and get the client to collaborate with you to overcome these problems.

Often sex workers have been disowned or rejected, or have actively distanced themselves from their families. When they have to live with HIV or become ill they may seek to reunite with their families and require counseling support.

Counseling for HIV-positive sex workers can assist them in:

- deciding whether to disclose their HIV status;
- discussing in a non-judgmental manner the potential legal implications of continuing to engage in sex work;
- planning strategies for disclosing their status to regular partners;
- ensuring access to treatment and care;
- addressing barriers to risk reduction posed by sex work and drug and alcohol use;
- facilitating family reunions and offering family counseling support;
- providing ongoing support and planning for the future;
- joining peer support programs;
- taking up income-generating projects; and
- Availing themselves of accommodation services as needed.

Section 6: drug and alcohol users

Drug or alcohol use, especially dependent is less likely to adhere on treatment and retain on care. So all efforts should be made to link them in various required interventions like opioid substitution therapy (OST) of the drug users are Opiod dependent, needle syringe program if they share needle and do not wish to take OST (however, continue counseling on risk reduction and benefits of OST for integration to family and society to be done in each visit and motivate client to discontinue the Injecting bahaviour) and help them adhere and retain on treatments. Drug use, can have a significant impact on a client's health and can complicate the treatment of other conditions.. Drug use, and in particular injecting drug use, is a major risk factor for blood-borne virus transmission. Counselors who work in HIV and other health services may often work with substance users in different ways including:

- providing counseling associated with HIV testing;
- providing counseling to facilitate transmission risk reduction, including counseling and referral to help clients to modify their drug use;
- supporting clients, their partners, and families in adapting to living with HIV;
- counseling family members on their support required to overcome substance dependency
- supporting the client in achieving adherence to HIV and other medical treatment (including opioid substitution therapy [OST]); and
- offering palliative counseling to clients who are in the final stages of their life.

How to assess drug and alcohol use

You must be aware of drugs commonly used by your clients, their method of use, and the signs, symptoms, and side-effects of their use. When assessing clients for substance use, counselors should pay close attention not only to signs of dependence but also to the harm arising from substance use. Many clients may show harm from substance use but may not be dependent. When assessing clients, only appropriately qualified counselors should make a diagnosis of dependence.

Recognizing drug use: signs and symptoms

Drug and alcohol use is commonly underreported and can be missed if you do not directly ask the client about such use. You should be aware of a client's drug use so that you can provide him or her with information and advice on how to reduce this risk. It is important that a drug use assessment be carried out in pre-HIV test counseling as part of the risk assessment, in any behaviour-change counseling session, and in supportive post-diagnosis counseling sessions. The clients may also possess dual risk of having unsafe sex or work as a sex worker and have substance abuse, so counseling and assessment of dual risk needs to done to provide counseling on risk reductions. Adherence to risk reduction and to HIV and STI treatments require ongoing supervision and support across the disease continuum. It is important to focus on all aspects of drug or alcohol use and not simply on a client's injecting drug use. Clients should also understand the relationship between sexual transmission and all types of drug use.

Different people use drugs and alcohol in different ways. A client may also use drugs or alcohol in different ways at different times of his or her life. To get a clear idea of a client's drug use it is necessary to determine the following:

- what drugs a client currently uses;
- what drugs the client has used in the past;
- how the client has used these drugs, including the pattern of drug use;
- whether the client is dependent on these drugs;
- whether this drug use is causing problems in the client's life; and

- how the client feels about his or her drug use and whether or not he/ she wants to change his/ her drug-use behaviour.

Because of the stigma associated with drug use a client may be reluctant to disclose drug use because he or she:

- feels embarrassed about the drug use and fears being judged because of it;
- fears being treated with contempt after admitting to drug use;
- is worried that admitting to drug use during a consultation could be incriminating (may have legal consequences); or
- does not see his or her drug use as a problem or as important enough to be mentioned to a doctor.

Overcoming reluctance to disclose drug or alcohol use. To gather the information needed for a complete drug-use history it is important to overcome a client's reluctance to talk about drug use. The client must feel that the counselor can be trusted and that it is safe to be open and honest. The counselor should therefore:

- maintain a non-judgemental attitude;
- acknowledge to the client that drug use can be difficult to talk about;
- assure the client that the consultation is confidential; and
- obtain the client's informed consent before taking a drug-use history.

Obtaining consent to take a drug-use history The client's right to autonomy over his or her treatment must be respected. This also applies to the client's participation in the process of assessment. It is appropriate to give the client an opportunity to decide whether or not to talk about the drug use. This will also make the assessment process more productive. Informed consent can be obtained in the following manner:

- Describe to the client the drug and alcohol treatment services that are available.
- Ask the client if he or she might be interested in these services.
- Explain that in order to provide such treatment it is necessary to assess drug use and dependence.
- Take time to explain what this assessment involves.
- Ask for the client's consent to conduct a drug-use assessment.

Identifying the drugs used. The use of some drugs or alcohol may be legal; the use of others may be illegal. People who use drugs commonly use, or have used, more than one substance. Certain substance-using behaviours may not be problematic, but the use of any drug can be problematic for most people. It is important to identify all substances, legal and illicit, injected and non-injected, that a client has used. These include substances that he or she uses currently or has used in the past. It is important to ask specifically about all the drugs listed below; otherwise, specific substances used may not be identified.

Ask: "Have you ever used [name of drug] before?"

- alcohol (beer, wine, spirits, etc.);
- tobacco (cigarettes, chewing tobacco, etc.);
- cannabis (marijuana, hashish etc.);
- opiates (opium, heroin, methadone, and other opioids);
- methamphetamine and amphetamines;
- cocaine (coke, crack cocaine, etc.);
- hallucinogens (lysergic acid diethylamide [LSD], hallucinogenic mushrooms, phencyclidine [PCP], ketamine, etc.);
- inhalants (nitrous oxide, petrol, glue, etc.)

- sedatives or sleeping pills (benzodiazepines, barbiturates, etc.); or
- any other substances. If a client has used any other substance not listed above have him or her specify what it is.

Determining the pattern of drug use. Because people use drugs and alcohol differently over time, it is important to gain an understanding of a client's pattern of drug use. The pattern for each drug used should be determined. Use patterns can be elicited as follows:

- "How old were you when you first used [name of drug]?"
- "How long did you use [name of drug] like this?"
- "When did that change?"
- "What was the pattern after that?"
- "How long did you use [name of drug] like this?", etc.
- "How often and in what amounts have you used [name of drug] in the last three months?"
- "When did you last use [name of drug]?"

How do I know if the client is substance-dependent?

Counselors must take care not to incorrectly label all substance users as being dependent. A diagnosis of dependence (see box 9.4) should be made only by a qualified physician or counselor.

Drug dependency (ICD-10 diagnostic guidelines)

A definite diagnosis of dependence syndrome is usually made only if three or more of the following were present together at some time during the previous year:

- evidence of tolerance, such that increased doses of the psychoactive substance are required to achieve effects originally produced by lower doses;
- physiological withdrawal state when substance use has ceased or has been reduced:
- strong desire or sense of compulsion to take the substance;
- difficulty controlling substance-taking behaviour – onset, termination, or levels of use;
- progressive neglect of alternative pleasures or interests because of psychoactive substance use – increased amount of time necessary to obtain or take the substance or to recover from its effects; or
- persistent substance use despite clear evidence of overtly harmful consequences – depressive mood states consequent to periods of heavy substance use or drug-related impairment of cognitive functioning.

Source: International Classification of Diseases (ICD) website: http://www.who.int/classifications/icd/en/

Ethical HIV testing and counseling of drug users

The importance of building trust between clients and providers cannot be overestimated. Many countries have adopted mandatory screening for high-risk populations such as PWIDs. It is likely that, instead of reducing HIV transmission in the community, such policies will be counterproductive. Many PWIDs may fail to request assistance with their substance dependency or their substance use if they know that they will be forced to test to gain access to health services. The development of good relationships between clients and health providers requires transparent procedures. Misleading clients into HIV testing will only reinforce their mistrust and ultimately their unwillingness to confide in health service providers. Ultimately a client's unwillingness to share information about exposure risk may translate into an increase in HIV transmission, and an unwillingness to share information

about treatment adherence may result in transmission of HIV and the development of resistance to HIV treatments.

HIV testing and associated counseling among PWID

Many substance users and in particular IDUs see little benefit in learning their HIV status. Often they are coerced into testing only to find that they are denied access not only to HIV treatments but also to other medical interventions when they test positive. From both an ethical and a public health perspective it is essential that we facilitate access to treatment and care services.

The acceptability of testing and counseling to drug users can be improved by involving current and former Is in service provision. They can be employed to mobilize other PWIDs to attend HIV testing and counseling services. These peer ”mobilizers” can be trained to discuss the benefits of HIV testing and what to expect during HIV testing and counseling, and to offer referral to selective services that provide ethical and high-quality HIV testing and counseling. Some peer educators act as ”HIV testing buddies” and accompany individuals to testing and counseling services, to confirm their status (if found reactive through CLT), help the new clients complete registration formalities, and provide companionship and emotional support to individuals while they await test results. Often these ”buddies” or can screen their HIV by themselves through CLT and accompany facilitate attendance by newly diagnosed individuals at their first peer support session and other referral services.

In some settings peer educators have been trained to provide pre- test information and post- test counseling under the supervision of health service providers. In many treatment and care facilities peer support clubs offer treatment adherence support to club clients receiving treatment and care for drug dependency and HIV.

Substance use and post-HIV test counseling

Many PWID have HIV tests while still actively engaged in substance use or during early detoxification from substance dependency. Counselors should check the client for signs of impaired cognitive function or comprehension before providing any result, positive or negative. Clients who are assessed as too impaired to comprehend the result and its implications should simply be informed that no result, whatever the status, can be provided at this time and offered a place to wait or an alternative time for getting the result. Be sure to write the time on a card as the client may not recall any information provided orally. Capacity to receive results can be assessed through observation, as well as a brief review of what was discussed at pretest and questions from the counselor to assess capacity to understand what has been discussed.

Special considerations in providing HIV-negative results

Service providers often dismiss the importance of counseling for individuals who receive negative results; hence, results are communicated in a cursory manner that pays poor dividends, with clients failing to make behaviour changes. You must provide clients with accurate information on the reduction of risk related to their specific substance use. Tools provided in the HIV Counseling Toolkit may help you give explicit information about risk reduction for IDUs. Motivational interviewing for behaviour change is discussed in chapter 3.

During acute infection HIV transmission is significant, and many drug users presenting will have had risks within the window period. Therefore, all clients need to understand the implications of window-period transmission. Explicit and concrete information should be provided about the need to retest for HIV to cover the possibility of HIV seroconversion. Clients must understand that the window period varies for different blood-borne pathogens such as HCV. Counselors must provide clients

with a clear written schedule of dates for ”follow-up tests” that cover the different window periods for each infection.

For all inconclusive reports client needs to be followed up in 14 days and repeat the test and/or prepare the sample for TNA PCR for confirmation.

Special considerations in providing HIV-positive results

The client’s capacity to cope with and adapt to the diagnosis should be assessed at the time the result is provided, even if this was already considered in pretest counseling. Specifically, there should be some attempt to assess whether the client has any suicidal thoughts or threatens harm to others as a result of the diagnosis. This discussion may be initiated by gently commenting, ”Some people feel they cannot live with this news and think of harming themselves or others. I am wondering if you feel this way.”

Because of the trauma associated with the result clients who are current substance users should be considered to be at high risk of either intentional or accidental overdose. For those who are not current users the possibility of relapse should be anticipated and discussed with the client. Motivational interviewing sessions may assist clients in anticipating and managing relapse triggers. Review chapter 3 for a description of these techniques.

Referrals

All newly diagnosed clients must undergo medical assessment to facilitate planning for their treatment and care needs. Health service providers must also discuss with the individual the potential benefits of allowing information regarding their health status to be shared between clinical service providers such as HIV physicians, and drug treatment and mental health professionals. The client must understand that treatments for HIV-related conditions will need to be considered in conjunction with other drug treatments and psychiatric services.

You should also offer follow-up counseling and support services or refer the client to an agency that can provide these services. In follow-up counseling sessions a variety of issues related to the diagnosis and future treatment may be discussed. The counselor focuses on the immediate post-diagnosis needs of the client with a view to facilitating an adaptive response to the diagnosis. While all of the usual post-diagnosis strategies should be performed, some special considerations for IDUs should be highlighted.

Referral models:

Referral is one of the important components of this project tenure in terms of providing quality services to the targeted population. Therefore, Counselor will manage internal and external referral services to the key population through outreach worker and counselors and hospital. Similarly, counselor need to referred clients to different services as per their need like :

- Psychosocial counseling, pathological testing, OST, PHC, detoxification, treatment and rehabilitation, care and support, income generating activities, ART observation, OIs, HIV Testing and Counseling (HTC), Community Home based Care (CHBC), nutrition and vocational support, Alcohol/Narcotic Anonymous meetings, Antiretroviral Therapy (ART), Directly Observed Treatment, Short-Course (DOTS), Sexually Transmitted Infection (STI), pathological testing, Prevention mother to child Transmission (PMTCT), People Living with HIV and AIDS (PLHA) networks, Legal support, Family planning, Hospital, Post exposure Prophylaxis (PEP), psychiatric

services within the government hospital, Shelter, nutrition and vocational support, Alcohol/ Narcotic Anonymous meetings.

Key counseling issues in post-diagnosis follow-up and support

Assessment of impact of the diagnosis. The ability of the client to manage the impact of the diagnosis must be regularly reviewed. The intent is not only to improve the quality of life of the client but also to facilitate adherence to transmission prevention, drug dependency, and HIV clinical treatments.

Problem solving. Clients often require more than just information to resolve their problems. Often they will need assistance in planning and rehearsing new behaviours. For some individuals diagnosed relatively late in the disease, especially those with years of chronic substance use, there may be co-morbid or HIV-related CNS complications that can impair cognitive functioning, making the client unable to initiate and adhere to a prevention and treatment programme. Such complications commonly affect these areas of cognitive functioning: planning and organization, speed of information processing, verbal fluency, short-term memory, and eye-hand coordination.

Mental health. Drug and alcohol dependency is one of the Mental health Disease, so referral and linkages to psycho-counselor and psychiatrist to be done a earliest.. It has been suggested that drug use makes the brain more vulnerable to HIV and HIV dementia, perhaps by affecting the immune system. In a number of cases drug or alcohol use may represent the client's attempt to manage symptoms of an undiagnosed, pre-existing mental illness. The provision of appropriate mental health support–psychiatric (antidepressant therapy) as well as psychological (e.g., cognitive behaviour therapy)–is an essential component of drug treatment services. Chapter 6 covers the conduct of a psychosocial assessment.

HIV-related neurological complications. Some studies suggest incidence of HIV encephalitis in the brains of 56% of HIV-positive drug users, compared with only 15% of HIV-positive non-users. Other studies indicate that clients with a history of injecting drug use who present with slowed psychomotor activity have a more rapid progression and show abundant macrophage activation within the CNS. But the degree to which substance use contributes to progression from minor neuro-cognitive disorders such as minor short-term memory loss to dementia remains unclear.

Decisions regarding treatment

Clients may have misconceptions about both HIV and drug dependency treatments offered, and may also need to discuss their fears and concerns. Some may need to engage the support of friends or family. Assistance may have to be provided to facilitate this.

Substance dependence (in particular to opioids) is a chronic relapsing condition, which is difficult to control because of compulsive drug use and craving, leading to drug seeking and repetitive use, even in the face of negative health and social consequences. A number of medical, psychiatric, and social problems common among substance-dependent people are important considerations in designing and delivering HIV and AIDS care.

Declining health as a result of HIV disease is a recognized risk factor for relapse into drug abuse. Physical and psychological stresses associated with HIV, such as pain, decreased functional ability, fatigue, and weakness, as well as fear, anxiety, and grief, all serve to increase an individual's risk of resuming substance use. Certain "milestones" in the progression of HIV present an increased risk of relapse and clients may need additional support at these times. Staff must review the client's treatment plan when one of these milestones is reached. Becoming symptomatic or receiving an AIDS diagnosis would be one such milestone.

Referral to specialized counseling and support services

Drug and alcohol counseling. Counselors who are not trained in drug and alcohol counseling are advised to refer the client who needs this type of counseling to specialized services. Such services typically provide drug and alcohol use assessments, and detoxification and rehabilitation programmes.

Detoxification services. Counselors should be aware that, while not an effective treatment for dependence, this short-term intervention has some benefit in allowing drug user to regain some control over their lives and gain insight into their dependency on the drug. Detoxification is aimed at easing the discomfort of drug withdrawal, preventing complications of self-managed withdrawal, preventing or treating destabilizing medical and psychiatric conditions, preventing polydrug overdose, intervening in social crises, interrupting a pattern of heavy and regular drug use, and finally facilitating linkage with post-withdrawal treatment options.

Post-withdrawal interventions. Drug dependency rehabilitation requires treatment beyond detoxification. Comprehensive rehabilitation should include various counseling models (supportive, behavioural, cognitive, dynamic), and a choice between residential rehabilitation and therapeutic community self-help groups (Narcotics Anonymous, Rational Recovery), on the one hand, and the use of naltrexone (an opioid antagonist that can reduce cravings and block the effects of additional heroin use; effective when taken daily but the drop-out rate is extremely high), on the other. Non-drug-related services offering employment or vocational training, education, and socialization outside the previous drug culture have been found to be beneficial as well.

Opioid substitution therapy programmes. Long-term OST attempts to reduce heroin and other drug use, mortality, the transmission of blood-borne viruses, and drug-related crime, and improve the patient's general health and well-being (psychosocial functioning). Methadone, a synthetic opioid that blocks the effects of heroin and other opioids, has been used for more than 30 years to eliminate withdrawal symptoms and relieve drug craving. Similarly Buprenorphine has also been successfully used to support change in injecting drug use bahavours. And both Methadone and Buprenorphine is provided in Nepal from OST centers

Other medications include levo-alpha acetyl methadol (LAAM), an alternative to methadone that blocks the effects of opioids for up to 72 hours, and naltrexone, a long-acting opioid blocker often used with highly motivated individuals in treatment programmes to promote complete abstinence and also to prevent relapse.

The combination of medication with psychosocial services repairs the damage to the client's psyche and socialization caused by years of illicit drug use and exclusion from the mainstream culture.

Family therapy. For many clients, "family" may need to be defined as broadly as possible. Supporting people in recovery from drug use is often a principal goal of family therapy. It may also be a useful opportunity to address issues of risk reduction for family members who are not HIV-positive and to provide emotional support to carers.

Positive peer support clubs. These may fulfill a wide range of needs: psychosocial support in modifying drug use, emotional support to members, and support for treatment adherence. Support groups may be segregated by gender, sexual orientation, and type of drug use, and also by stages of recovery from addiction or HIV infection (newly diagnosed, asymptomatic or mildly symptomatic, advanced disease).

Partner counseling. This should focus especially on issues of sexual transmission, contraception, prevention of STI and possibly super infections, and prevention of mother-to-child transmission (PMTCT). PMTCT does not seem to sit as well with positive peer support clubs.

PMTCT services. Counselors need to assist all clients in preventing unplanned pregnancies especially during periods of potential exposure or suspected acute infection. It is also important to have partners of pregnant women screened and aware of the risk of transmission to unborn children. Counselors must increase client awareness of the heightened risk of transmission during seroconversion, as well as the impact of continued substance use on the unborn or breast-fed child.

NA/AA group. Counselor need to refer Narcotics Anonymous (NA) and Alcohol Anonymous (AA) meeting, which is a twelve-step program where people who are addicted to drugs can find support in recovery. It is a group of recovering drugs addicts helping each other to remain clean. The NA/AA literature describes it as a program "for addicts who wish to pursue and maintain a drug-free lifestyle.

Table 9.1 Expected Behaviors/Practices and Key Messages for IDUs

Expected Behaviors/Practices	Key Messages
• Use new syringe and needle every time	• HIV and STI are transmitted through sharing needle and syringes and sex with multiple sex partners without using condoms • HIV can be prevented by using new syringe and needle every time of injecting drugs. • Don't use syringe and needles used by others. • Don't share needles • Seek help of health care service providers to access to rehabilitation and oral substitution therapy • Don't mingle with friends who use drugs and force you to use drug • Use alcohol swab properly before inject.

• Reduce the number of sexual partners • Use condoms correctly and consistently • Seek regular checkups and treat STIs (quarterly) • Refer sexual partners for STI	• Unsafe sex with multiple partners increases the risk of getting HIV and STIs. It also increases the chance of unintended pregnancy. • Consistent and correct use of condoms can protect a person from HIV and STIs as well as unintended pregnancy • Condom use can make sex not only safer and but also pleasurable • Demonstrate correct use of condoms (step by step) • A healthy looking person can be infected with HIV and STIs • Condom can protects both from HIV/STI and unwanted pregnancy. Using one condom correctly at a time of sexual contact is enough to protect from HIV and STI. No need to wear more than one condom at a time. • There are different types of condoms with different flavor in the market. • Regular checkups (quarterly) for STIs are important even when no symptoms are present. Many STIs are asymptomatic and may only be detected upon examination. Regular visits to the clinic accomplish more than just STI treatment – they provide an opportunity for education and counseling, and promote health awareness and wellness. • STIs are also transmitted through needle and syringe sharing. • Many STIs are curable if treated in a timely manner and properly by skilled clinicians. • 3 Cs (Consistent and correct condom use, complete treatment/ compliance and contact tracing/partner notification, checkups and treatment) should be followed during STI treatment. • Complications of STIs if not treated quickly and completely • A healthy looking person might have HIV and/or STIs
• Seek HTC services (quarterly) • Refer sexual partners to HTC	• The only way to know HIV status is HIV counseling and testing. Clients who are not using condoms consistently and correctly need HIV counseling and testing every three months. • Window period-the Rapid test detects HIV antibodies in the blood (does not detect HIV) and it take 3 months for the body to build up enough antibodies for the test to detect them • Healthy looking person might have HIV and/or STIs • If diagnosed HIV negative, one can protect oneself form HIV • If diagnosed positive, no need to worry, there are several ways to protect and improve your health. Care, support and treatment services are available

Section 7: pre-exposure prophylaxis

HIV pre-exposure prophylaxis (PrEP) is use of antiretroviral drugs before exposure to HIV to prevent potential transmission. If taken as instructed, this medicine has been shown to reduce risk of HIV infection more than 90%. PrEP is not 100% effective. The medicines used for PrEP are of the same group of medicines as those used for treatment of HIV infection.

PrEP is a complementary intervention to reach those who are not using the traditional methods of HIV prevention-including condoms and behavior change approaches, and to promote combination prevention. World Health Organization (WHO), the most recently has recommended PrEP for any individual at "substantial risk" of HIV (WHO, 2016). PrEP can be used daily or according to risk of exposure. Daily PrEP is recommended for those who are in regular risk. Event based PrEP can be used to prevent occasional exposure.

The World Health Organization recommends that PrEP containing tenofovir disoproxil fumarate (TDF) should be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination prevention approaches (WHO, 2016). In Nepal daily PrEP is recommended. The generic combination of Tenofovir and emtricitabine is the recommended ARV. for PrEP.

The messages provided during for PrEP should include the following:

- Pre-exposure prophylaxis (PrEP) is when people take an HIV medication to reduce their chance of getting infected while they are at risk of acquiring HIV. WHO currently recommends the use of PrEP taken daily for both men and women who are at substantial risk of acquiring HIV. You should take PrEP every day – if you do not take it every day it may be less effective.
- PrEP does not provide 100% protection, but it is highly effective and provides a great deal of protection against HIV. In some recent studies, PrEP has been shown to reduce the risk of HIV infection during sex by over 90% when used consistently.
- PrEP is more effective for those who take PrEP regularly (that is, who are adherent) than for those who often miss their daily dose. Taking PrEP every day is recommended because daily use of PrEP is effective, safe and the most convenient approach. Daily PrEP use provides the highest amount of medication in the blood and body tissues and, thus, the highest level of protection. If you take PrEP daily, you may still be protected, even if you miss a dose once in a while.
- Time is needed to build up protective levels of the medicine in the blood and other tissues. Additional HIV prevention should be taken for the first seven days when starting PrEP. Ways to lower risk during this period include adopting safer sexual practices, such as not having vaginal or anal intercourse, or using condoms.
- It is suggested that PrEP should be continued for 28 days after the last potential exposure to HIV.
- People who already have HIV should not take PrEP. Instead, they should be offered antiretroviral therapy. People with kidney disease should not use PrEP containing tenofovir.
- Some people may have early side effects such as an upset stomach, dizziness, headache, or weight loss but these are usually mild and go away after a few days.
- PrEP is not recommended for all. Only for those who are HIV-negative and at high risk for HIV infection should take it. That includes anyone having sex with an HIV-positive partner, those who do not always use condoms when having sexual intercourse, people who exchange sex for money or other things and those who use drugs for sexual pleasure. Also, people who have sexually transmitted infections are candidates for PrEP.
- PrEP does not require the use of condoms to be effective. However, condoms provide additional protection against HIV and protect you from other sexually transmitted infections and unplanned pregnancies:

- PrEP does not prevent sexually transmitted infections, such as syphilis, gonorrhea, chlamydia and hepatitis. Condoms, however, do provide protection against these other infections as well as against HIV, and so they protect your overall sexual health.
- PrEP does not prevent pregnancy. When used consistently, condoms prevent pregnancy. There are many other ways to prevent pregnancy, including oral contraceptive pills and injectable hormones, implants, intrauterine devices and diaphragms. PrEP does not interfere with any contraceptive method.
- People who take PrEP need to get a check-up and HIV test before they start and test regularly after that.

Table 9.2 Difference between ART and PrEP

ART	PrEP
• Taken by HIV infected persons to remain healthy and prevent onward transmission. • Requires monitoring of side effects, viral load and CD4 at regular interval • Requires adherence with consistent, fully suppressive dosing. • Cannot be discontinued	• Taken by HIV uninfected persons who are largely healthy to prevent acquisition of infection during “periods” of high HIV risk. • Individuals require ongoing risk assessment and PrEP can be discontinued if they: • acquire HIV infection. • are no longer at substantial risk for HIV infection. • decide to use other effective prevention methods. • This is used as comprehensive prevention method. • Provided only two types of ARV (TDF/ FTC) in fixed dose combination.

Section 8: post exposure prophylaxis

What is the risk of infection?

The average estimated risk of HIV infection for health-care workers after percutaneous or mucous exposure is less than 0.5%. The risk of transmission from exposure to infected fluids or tissues is lower than that for exposure to infected blood. In the majority of documented exposures, nurses undergo percutaneous exposure to the blood of a patient with AIDS when placing a device in an artery or vein. Transmission through splashes, cuts, and skin contaminations is also possible, although the risk of infection in such cases is comparatively low. In addition to being assessed for the risk of exposure to HIV, health workers should be assessed for exposure to HBV and HCV as well as other blood-borne pathogens.

i. providing counseling and emotional support after an exposure

The first HIV test after exposure will be a baseline test. This first test will reflect only previous exposure arising from the worker's personal risks. In high-prevalence countries many people will have a seropositive HIV test result at this stage, as HIV prevalence among health workers, for example, often reflects prevalence in the general population. It is therefore important that the health worker knows this, and undergoes individual pretest information and personal risk assessment.

A baseline HIV test on a health worker may be carried out in a location other than the place of work, such as an anonymous testing clinic, to help maintain the confidentiality of the information. If the worker's employer should require proof later on that the worker tested negative at the time of exposure, the result can be given to the employer with the health worker's consent. The sequence of actions after a reported exposure may vary depending on local policy.

If the worker presents immediately after sustaining a potential exposure, first aid should be administered before any counseling or testing. This may include, for example, washing with cool mild soap in a running water. Any squeezing of the injured wound should not be done. It is not advised apply spirit or any antiseptics .An exposure risk assessment is then conducted. It should analyse in detail the nature of the exposure (wound depth, type and quantity of body fluid, etc). The source patient may, with his or her informed consent, be requested to test. Immediately after the accident exposure, the doctor or another designated health-care worker should evaluate the risk of infection according to:

- severity of the exposure;
- depth of injury;
- duration of exposure;
- type of instrument or needle involved (hollow-bore or suture needle);
- serological status of the patient;
- stage of disease (symptomatic or asymptomatic, high or low viral load or CD4 count) of the source patient; and

ARV resistance in the source patient, if on ART.

In general, taking all the above factors and the type of exposure into consideration, doctors should be able to assess the risk associated with the exposure and recommend the course of action to be taken. Counselors need to discuss the level of the risk of exposure with the doctor before providing feedback to the client.

The source patient should be tested only if he or she has access to pre- and post-test counseling and gives informed consent. If the source patient is being treated for a non-HIV condition it may be

useful to inquire if he or she has taken or is taking medication prescribed for HIV and, if so, which specific medication. The exposed health worker should not be asked to approach the source patient for permission to have the patient tested for HIV. If the source patient tests negative, this does not mean that he or she is uninfected. Window-period exposure should also be considered and a risk assessment should be carried out to be able to decide whether or not to initiate PEP.

PEP should be prescribed only after informed consent is obtained from the health worker. The procedure will vary across different settings. Combination of triple drug therapy, irrespective of type of exposure and the status of the source of exposure–is recommended, as it is believed to be more effective than a single agent. The therapeutic regimen will depend on the drugs taken previously by the source patient and known or possible cross-resistance to different drugs. It may also be determined by the seriousness of the exposure and the availability of the various ARVs in that particular setting. ART should be provided according to national protocol (and made available as a PEP ”kit”) or, when possible, in consultation with a medical specialist. It is advisable for each service delivery point to keep a starter pack with seven days dose to start. Expert consultation is especially important when a client may have been exposed to drug-resistant HIV. Health-care workers must have ready access to a full month’s supply of ARV once PEP is begun.

Pretest information session should precede any baseline blood testing. The health worker must be informed that the initial test will only reflect his or her status at the time of the injury and therefore his or her personal risk history. A confidential personal risk assessment is recommended. For privacy reasons a health worker may opt to have this baseline test done elsewhere and the results provided to the employer only if a later follow-up test shows that seroconversion has occurred.

It is important to remind workers to attend follow-up testing. This sequence should take into account the different seroconversion periods for different infections and, if the worker is to undergo PEP, the longer seroconversion period that could occur. In Nepal follow up testing for each medical occupational exposure after PEP is recommended in six weeks, three months and six months period.

Psychosocial support counseling should ascertain if the worker has additional support needs. It is not uncommon for workers to experience anxiety, depression, and sleeplessness. Attitudes to caring for their clients may be influenced by their psychological response to the exposure. Many may have to consider practising safer sex even within a relationship in which they do not normally practice it.

While health workers experience many of the same issues that confront any member of the community in relationship to treatment adherence, some issues specific to health workers may include:

- fear that work colleagues may see them take medication and make assumptions about their HIV status;
- difficulties experienced at work because of the side-effects;
- possible overemphasis on the potential for seroconversion and HIV illness resulting from having to deal daily with patients who have HIV or advanced AIDS; and
- anxiety in the pregnant health worker about the impact of the regimen on the fetus.

Counselors should review the sequence of events that preceded the exposure in a sensitive and non-judgemental way in order to advise the worker on ways to protect himself or herself from future exposure. You must address the following in addition to all of the normal issues during post-test counseling:

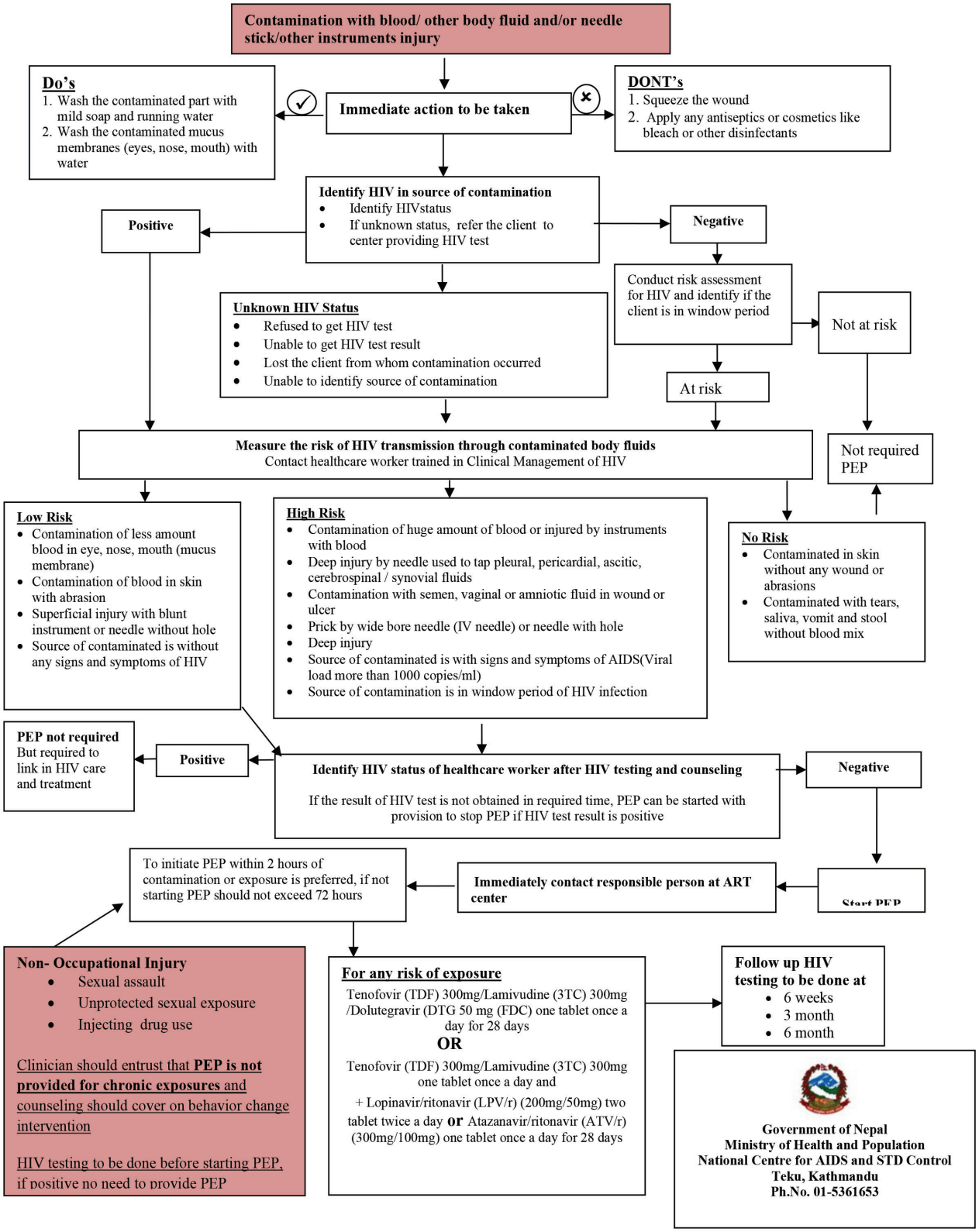
- how the exposed worker is coping emotionally with the waiting for follow-up test results;
- appointments for follow-up testing, where required; and
- emotional support related to the diagnosis

Summarized below is the flow of HTC services in the management of occupational exposure.

Summary of HTC service flow in the management of occupational exposure

- First aid: Was it performed? If not, advise on first aid if exposure has just occurred. For example, for needlestick exposure, bleed the wound and wash it with mild soapy water. Blood splashed into the eyes should be flushed with sterile water immediately.
- Exposure risk assessment and feedback on risk: Using the four principles of transmission (exit, survive, sufficient, enter), consider whether needle was hollow bore, splash was to unbroken skin, etc.
- Prophylaxis counseling, including informed consent for ARVs
  - evidence for intervention, avoiding unrealistic promises of altering the course of HIV
  - potential side-effects and strategies for management
  - prolonged window period (up to six months when on PEP)
  - adherence issues
- Pretest counseling: – all normal pretest counseling plus:
  - how to reduce future occupational exposure
  - testing procedures to cover window period
  - worker's compensation, insurance, and other formalities
  - when to present for follow-up test
- Blood sample drawn for baseline HIV test and other serological tests
- Post-test counseling and scheduling of follow-up tests

Management of Post Exposure Prophylaxis



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Annex 1

Counseling code of ethics

The purpose of the counseling code of ethics is to:

- establish and maintain standards for counselors; and
- inform and protect members of the public who seek and use their services.

The code of ethics outlines the fundamental values of counseling, namely, integrity, impartiality, and respect. A number of general principles arise from these. They address such issues as client safety, clear contracting, and competence. Counseling is a non-exploitative activity and counselors should have the same ethical values in both voluntary and paid counseling positions.

Your responsibilities to the client safety

- Counselors should take all reasonable steps to ensure that the client suffers neither physical nor psychological harm during counseling.

Client autonomy

- Counselors must not exploit their clients financially, sexually, emotionally, or in any other way. Engaging in sexual activity with the client is unethical.
- Counselors are responsible for working in ways that promote the client's control over his or her own life, and respects the client's ability to make decisions and change in the light of his or her own beliefs and values.
- Counselors do not normally act on behalf of their clients, unless at their express request or in certain exceptional circumstances.
- Counselors are responsible for setting and monitoring boundaries between the counseling relationship and any other kind of relationship, and making these boundaries explicit to the client.
- Clients should be offered privacy during counseling. The client should not be observed by anyone other than their counselor or counselors unless they give informed consent. This also applies to photos/audiotaping/videotaping of counseling sessions.

Contracting

- Counselors are responsible for communicating the terms on which counseling is being offered, including availability, the degree of confidentiality offered, and their expectations of clients.
- It is the client's choice whether or not to participate in counseling. Reasonable steps should be taken in the course of the counseling relationship to ensure that the client is given an opportunity to review the terms on which counseling is being offered and the methods of counseling being used.
- If records of counseling sessions are kept, clients should be made aware of this. At the client's request, information should be given about access to these records, their availability to other people, and the degree of security with which they are kept.
- Counselors should gain the client's permission before conferring with other professional workers.

Counselor competence

- Counselors should monitor actively the limitations of their own competence through counseling supervision or consultative support, and by seeking the views of their clients and other counselors.
- Counselors should not counsel when their functioning is impaired by personal or emotional difficulties, illness, disability, alcohol, or drugs, or for any other reason.
- It is an indication of the competence of counselors when they recognize their inability to counsel a client and make appropriate referrals.

Responsibility to self as a counselor

- Counselors have a responsibility to themselves and their clients to maintain their own effectiveness, resilience, and ability to help clients. They are expected to monitor their own functioning and to seek help or withdraw from counseling, whether temporarily or permanently, when their personal resources are sufficiently depleted to require this.
- Counselors should receive basic counseling training before starting counseling, and should maintain ongoing professional development.
- Counselors should take all reasonable steps to ensure their own physical safety.

Responsibility to other counselors

- A counselor who suspects misconduct by another counselor that cannot be resolved or remedied after discussion with the counselor concerned should implement a complaints procedure (if there is any) without unnecessary breaches of confidentiality.

Responsibility to colleagues, members of the caring professions, and the community

- Counselors should be accountable for their services to colleagues, employers, and funding bodies as appropriate. This should be achieved with respect for the client's needs.
- No colleague or member of the caring professions should be led to believe that a service is being offered by the counselor when it is not, as this may deprive the client of the offer of such a service from elsewhere.
- Counselors should work within the law and should take all reasonable steps to be aware of all current laws affecting their work.

Counseling supervision/Consultative support

- It is a breach of ethical requirement for counselors to practice without counseling supervision or consultative support.
- Counseling supervision/Consultative support refers to a formal arrangement that enables counselors to discuss their counseling regularly with one or more people who have an understanding of counseling and counseling supervision/consultative support. It is a confidential relationship whose purpose is to ensure the efficacy of the counselor-client relationship.
- Counselors who have line managers owe them appropriate managerial accountability for their work. The counselor supervisor role should be independent of the line manager role. However, where the counseling supervisor role is also the line manager, the counselor should also have access to independent consultative support.
- The volume of supervision should be in proportion to the volume of counseling work undertaken and the experience of the counselor.
- Whenever possible, the discussion of cases within supervision/consultative support should

take place without revealing the personal identity of the client.

Research

- The use of personally identifiable material gained from clients or by the observation of counseling should be used only after the client has given consent, usually in writing, and care has been taken to ensure that consent was given freely.

Confidentiality issues

Confidentiality with respect to clients, colleagues, and others

- Confidentiality is a means of providing the client with safety and privacy.
- Counselors treat with confidence personal information about clients, whether obtained directly or indirectly or by inference.
- Counselors should work within the current agreement with their client about confidentiality.
- Exceptional circumstances may arise which give the counselor good grounds to believe that the client will cause physical harm to him or her. In such circumstances the client's consent to a change in the agreement about confidentiality should be sought whenever possible unless there are also good grounds for believing the client is no longer able to take responsibility for his or her own actions. Whenever possible, the decision to break confidentiality agreed on by a counselor and client should be made only after consultation with a counseling supervisor or experienced counselor.
- Any breach of confidentiality should be minimized both by restricting the information conveyed to that which is pertinent to the immediate situation and to those persons who can provide the help required by the client. The ethical considerations involve balancing between acting in the best interests of the client and in ways that enable clients to resume taking responsibility for their actions, and the counselor's responsibilities to the wider community.
- Counselors should take all reasonable steps to communicate clearly the extent of the confidentiality they are offering to clients. This should normally be made clear in the pre-counseling or initial contracting.
- If counselors include consultations with colleagues and others within the confidential relationship, this should be stated to the client at the start of counseling.
- Care should be taken to ensure that personally identifiable information is not transmitted through overlapping networks of confidential relationships.
- It is therefore good practice to avoid identifying specific clients during counseling supervision/ consultative support and other consultations, unless there are sound reasons for doing so.
- Any agreement between the counselor and the client about confidentiality may be reviewed and changed by joint negotiations.
- Agreements about confidentiality continue after the client's death unless there are overriding legal or ethical considerations.
- Any discussion between the counselor and others should be purposeful and not trivial.

Annex 2

Adherence calculation tool

Adherence calculation tool from pill counts

$$\% \text{ Adherence} = \frac{\text{Total \# of pills patient should have taken} - \text{\# of pills missed}}{\text{Total \# of pills patient should have taken}} \times 100$$

Name of medication	Number of pills dispensed	Number of pills patient is expected to have taken (A) (take into account whether patient has come early, on time, or after the refill due date)	Number of pills patient actually took (take into account remaining pills and whether patient has come early, on time, or after the refill due date)	Number of pills missed (B)	% Adherence $\frac{A-B}{A} \times 100$
Example: D4T one tablet taken twice daily	60 (for 30 days)	54 (patient came in 3 days early)	50 (10 pills remaining when there should have been only 6)	4	$\frac{54-4}{54} \times 100$ = 92.5%

Adherence could be <100% when patients have taken fewer pills than required or >100% when they have taken extra pills by mistake.

Adherence from self-report

Adherence measured using a self-report will only reflect the adherence over the period of recall; e.g. 3 days in the table below.

Patients should be asked about missed doses: how many doses of d4T did you miss – yesterday, the day before that and the day before that (3 days ago)?

$$\text{Adherence} = \frac{\text{\# of doses patient should have taken - \#of doses missed}}{\text{\# of doses patient should have taken}} \times 100$$

Names of medications	Yesterday (missed dose)	Day before yesterday (missed dose)	The day before that (3 days back) (missed dose)	% Adherence
Example: d4T one tablet taken twice daily	0	1	1	$\frac{6-2}{6} \times 100 = 67\%$

Source: Population Council/Family Health International. Adherence to antiretroviral therapy in adults: A guide for trainers. Population Council India, 2004. p.102.

Annex 3

What are psychoactive drugs and substances?

A psychoactive drug is any substance that, when taken by a person modifies perception, mood, thinking (cognition), behavior, or motor functions. This definition is broad; it includes both licit (legal) and illicit (illegal) substances, those that can lead to dependence (of the individual).

What substances do young people commonly use?

Students may provide a variety of names of different drugs. The facilitator should try to have the students determine which names actually refer to the same drug. It is common to find that a substance has a generic name, a trade name, and at least one street name. The names are not so important. What is important is to be able to recognize the local substances. The following table is for the teacher's reference.

Name	Examples
Alcohol	
Nicotine	Cigarettes, cigars, pipe tobacco, chewed tobacco, snuff
Cannabis	Marijuana, ganja, hashish, bhang
Stimulants	Cocaine, crack, khat, and "designer" substances such as amphetamines and methamphetamines, ecstasy
Opioids	Codeine, heroin, morphine, opium, buprenorphine, spasmo proxyvon, pentazocine, methadone, oxycodone, fentanyl, pethidine
Depressants	Sleeping pills, benzodiazepines, methaqualone, barbiturates, chloral hydrate
Hallucinogens	Lysergic acid diethylamide (LSD), mescaline, psilocybin, peyote, ayahuasca
Over-the-counter pharmaceutical preparations	Antihistamines, cough syrups, antidiarrhoeal drugs, anti-anxiety drugs
Volatile inhalants solvents, nitrites	Aerosol sprays, butane gas, petrol/gasoline, glue, paint thinners,

What are the different methods of use?

Substances can be taken into the body by many different means. The methods by which substances are taken influence how quickly the substance can produce its effects and also the different health consequences that the individual may experience. It is important to note that the same type of substance may produce the effect faster or more slowly depending on where, specifically, the substance is introduced. For example, injecting the substance into the muscle will not produce the effect as quickly as injecting it into the veins. Absorption through the mucous membrane of the nose is faster than absorption through other mucous membranes. Below are common ways that people take substances:

- injected with a needle under the skin, into a vein or muscle;
- smoked or inhaled through the mouth or nose;
- placed on a mucous membrane (the nose or under the eyelid);

Source: World Health Organization and United Nations International Drug Control Program. Primary prevention of substance abuse: A workbook for project operators., WHO and UNIDCP, 2003. pp. 17-19.

- chewed, swallowed or dissolved in the mouth; or
- rubbed into the skin.

Effects of drug and alcohol use

Here it is important to stress the fact that while drug or alcohol use has many desired effects, these effects are outweighed by the negative consequences. The effects of these substances can be short- or long-term. Short-term effects occur shortly after the substance is taken into the body, and these are influenced by the dose, the method of administration, and whether or not the substance is used in combination with other substances. The long-term effects are usually due to damage to the body organs. Other important factors that influence the effects are the individual, the substance, and the setting in which the substance is used. For the individual, this includes the person's physical condition and state of mental health, their expectations about the substance, and their past experiences with the substance. Substance-related factors that influence effect include the dose and method of administration. Lastly, factors involved in the setting can include expectations of others and the nature of materials used to take the substance into the body. Consider the example of a group of young people at a party or an environment where the sharing of needs takes place.

The following two boxes summarize what is known about the effects of the common substances.

Substance	Short-term effects	Long-term effects
Alcohol	Short-term effects include doing things that normally one would stop oneself from doing, possible loss of physical speech, poor decisions, and impaired coordination, unclear vision, slurred memory. Excessive drinking over a short period of time can cause headache, nausea, vomiting, deep unconsciousness, and death.	Drinking large amounts of alcohol regularly over a lengthy period of time can cause loss of appetite, vitamin deficiency, skin problems, depression, loss of sexual drive and memory, and liver and brain damage. Alcohol consumption during pregnancy can lead to fetal alcohol syndrome. Tolerance and dependence also develop.
Nicotine	Some short-term effects are: a feeling of alertness just after using tobacco and then relaxation afterwards, increase in heart rate, and a temporary rise in blood pressure. Dizziness, nausea, and reduced appetite also occur.	Long-term nicotine use can cause heart and lung disease, blockage of arteries (peripheral vascular disease), hypertension, bronchitis, cancer of the lungs, and cancers of the mouth (with pipe smoking and tobacco chewing).
Cannabis	Cannabis may make the individual feel euphoric at first and then relaxed and calm. There are feelings of well-being and relaxation, loss of inhibitions, muscle coordination, and concentration. There may also be increased heart rate, redness of the eyes, and increased appetite. Large quantities can cause panic, hallucinations, restlessness, and confusion. Large doses can also change physical perceptions, in the same way as hallucinogens.	Regular use over a long period of time increases the chance of dependence, causes impairment of cognitive functions, and may worsen existing mental problems.

Opioids	These produce detached and dreamy sensations, sleepiness, and constriction of the pupils of the eyes, nausea, vomiting, and constipation. Overdose leads to unconsciousness, inability to breathe, and death.	Tolerance and physical and mental dependence can develop quickly. Stopping use results in withdrawal syndrome.

3 From World Health Organization and United Nations International Drug Control Program. Primary prevention of substance Abuse: A facilitator guide. WHO and UNIDCP, 2003. pp. 23-25.

Substance	Short-term effects	Long-term effects
Stimulants	Short-term effects include enhanced or increased central nervous system activity, a brief intense feeling of intoxication, and exaggerated feelings of confidence. Soon the mood quickly changes to a low feeling, prompting the person to repeat the dose. Overdose is more common with crack than with other forms of cocaine.	Long-term effects include inability to sleep, irritability, mental health problems, and suspiciousness and mistrust of others (paranoia).
Depressants	Effects are similar to those of alcohol. They slow down a person's thinking and movements and decrease the ability to concentrate. They cause effects such as slurred speech, sleepiness, and problems with coordination, and cause "hangovers". Low doses reduce feelings of anxiety, while higher doses cause sleepiness. Consumption of alcohol (at the same time) increases their effect, and repeated doses cause toxicity because the substance cannot be broken down (metabolized) quickly. Accidents and suicide are common.	Substances in this category can lead to dependence, inability to learn, and problems with coordination. Convulsions can occur when the substance is withdrawn.
Hallucinogens	Hallucinogens can alter a person's mood, the way the person perceives his or her surroundings, and the way the person experiences his or her own body. Things may look, smell, sound, taste, or feel different, and one may see, smell, taste, hear, or feel things that do not exist. For example, the individual may see colours, lights, or images, or have an altered awareness of things happening inside or outside the body. Other short-term effects are feelings of panic, fear, or anxiety. A "bad trip" usually refers to an unpleasant and disturbing mental/ emotional state caused by hallucinogens. Accidents and suicide are common.	Tolerance can develop. Many individuals who have used hallucinogens report feeling effects produced by the substance days or even months after last taking the substance. These replays of past effects are often called" flashbacks". Regular use of hallucinogens can decrease memory and concentration. The flashbacks can also result in disorientation, anxiety, and distress.

Volatile inhalants	The individual feels uninhibited at first and drowsy later. With continued inhalation, hallucinations may occur. Other effects include feelings of happiness, relaxation, sleepiness, poor muscle coordination, slurred speech irritability, and anxiety. The most immediate danger to the individual is ”sudden sniffing death”.	Although little is known about volatile substances, regular long-term use may lead to nose bleeds, skin rashes around the mouth and nose, loss of appetite, and lack of motivation. Some of the solvents are toxic to the liver, kidney, or heart and some may cause brain damage. Little is known about the long- term effects of regular inhalant use.

Annex 4

Counseling strategies for reducing disclosure-related violence

Fear of violence is a major barrier to disclosure of HIV status by women to male partners. However, men are also subject to partner, familial, or community-related violence related to disclosure.

Social marketing of HIV testing and counseling (HTC) in communities could target couples and encourage joint HIV testing, as studies demonstrate that where couples test together, or at least discuss the decision to test with each other, the risk of disclosure-related violence is reduced. Counselors should create opportunities for sexual histories of couples to be undertaken separately. This not only ensures accurate risk assessment but also offers the counselor an opportunity to foresee potential relationship difficulties that may arise from the disclosure of an HIV-positive result.

Assessment. In addition to engaging in the standard process of disclosure counseling it is important to assess the couple's history and potential for violence, preferably at both pre- and post-test counseling sessions. This should be done with the women in an interview separate from that with her partner and reassuring about confidentiality. The table below shows suggested questions for use in assessing for potential disclosure-related violence. Where the threat is less tangible and there is little to suggest a real threat but the client is anxious, encourage couple disclosure of results with the counselor. Develop a "disclosure plan" with the client and include planning for an aggressive response. It is important that counselors maintain a referral directory of welfare agencies offering support to women (e.g., shelter from domestic violence).

Suggested questions to use to assess for potential disclosure related violence

"There are some routine questions that I ask all of my clients because some are in relationships where they are afraid their partners or families may hurt them"

"What response would you anticipate from your partner if your test comes back HIV-positive?"

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If the client indicates that he or she is fearful or concerned, then proceed as follows:

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"Have you ever felt afraid of your partner or family?"

"Has your partner or anybody in your family ever…

- "…pushed, grabbed, slapped, choked, or kicked you?"
- "…threatened to hurt you, your children, or someone close to you?"
- "…stalked or followed you or monitored your movements?"

↓

If the client responds affirmatively to any of these points, add:

"From what you have told me, do you think telling your partner about your result will result in risk to you or your children's safety?"

↓

The client should make the decision to disclose on the basis of a realistic appraisal of the threat.

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