

Programme guidance on

Counselling for STI/HIV prevention in sexual and reproductive health settings



International
Planned
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Federation



For counsellors,
health workers, educators
and all those working
in STI/HIV/AIDS



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ERRATA

Since these guidelines were written new data has led to the recommendation that spermicides, particularly nonoxynol - 9, should not be used for STI/HIV prevention and this includes lubricants containing the same.

Where saliva is also mentioned as a possible lubricant this would not be recommended.

Please take note when reading the guidelines.

Acknowledgements

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- Counselling Guidelines on Disclosure of HIV Status. South African AIDS Training (SAT) Programme. 2001
- Counselling Guidelines on Domestic Violence. SAT Programme. 2001
- Zimbabwe HIV Prevention Counselling Training Manual
- Counselling and Sexuality: A Video Based Training Resource. IPPF 1992

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IPPF Central Office

Regent's College,

Inner Circle, Regent's Park,

London NW1 4NS, UK

Telephone: +44 (020) 7487 7900

Fax: +44 (020) 7487 7950

Email: info@ippf.org.

Website: www.ippf.org

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Preface

IPPF is committed to providing support to FPAs to integrate STI/HIV prevention and counselling in the broad field of family planning and sexual and reproductive health. In many reproductive health settings worldwide STI/HIV prevention and counselling services are provided or there is a wish to do so.

This guide is designed to help workers, within FPAs and beyond, to improve their professional skills, in integrating STI/HIV prevention and counselling in their work in a systematic way. The purpose is to improve the effectiveness of their work and the quality of the contribution their work makes to the lives of the people it aims to support.

Who can use this guide?

This guide is aimed at all those who are concerned about integrating STI/HIV prevention in family planning work and who (intend to) do counselling in this field.

It addresses newcomers as well as the more experienced counsellors. The level of experience of working as a counsellor differs widely between reproductive health settings. Therefore some readers may find the guidelines on counselling too basic, while others might think some parts are very new to them. This last group might consider some extra training in counselling skills. We expect, however, that this document contains useful information for a broad range of people involved in working in counselling in family planning and sexual and reproductive health.

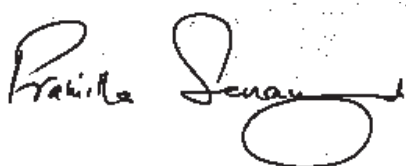
What is the purpose of this guide?

This guide aims to provide information, ideas and suggestions for those who work with clients (young people, male and female clients, individuals and couples) and who want to improve their knowledge and skills in counselling in STI/HIV prevention, safer sex, pre and post HIV antibody testing and other issues related to the subject. Depending on the needs, the reader may use this guide in different ways. Some may find information on particular issues of interest to them, others may use the guide to improve their counselling skills, or as a training tool for their staff.

We hope you will use the sections you find most helpful and adapt the guide to suit local needs and culture.

Furthermore, don't consider this guide as a 'closed file'. It needs to be revised and updated regularly.

Finally, Good Luck!



*Dr Pramilla Senanayake, MBBS. FRCOG, Ph.D.
Assistant Director General, IPPF*

Table of contents

page 6	1	INTEGRATING COUNSELLING ON SEXUALLY TRANSMITTED INFECTIONS AND HIV INTO FAMILY PLANNING COUNSELLING
6	1.1	Why should family planning providers get involved in STI/HIV counselling?
6	1.2	Planning to integrate STI/HIV counselling into family planning services
9	1.3	What ethical and legal issues will you have to address?
10	1.4	Specific issues for clients in different situations
13	2	COUNSELLING SKILLS AND PROCESSES
13	2.1	What is Counselling?
13	2.2	What attitudes do counsellors need?
14	2.3	What skills does a counsellor need?
15	2.4	The Counselling Process
18	3	COUNSELLING ON SEXUALITY
18	3.1	Counselling on sexuality and sexual expressions
21	4	COUNSELLING ON SAFER SEX, STI/HIV
21	4.1	The risk of STI/HIV transmission in different sexual activities
23	4.2	Introducing the issue of STI/HIV
23	4.3	Helping clients to assess their risk of STI and HIV infection
24	4.4	Helping clients to make a plan of action to reduce the risk of STI/HIV infection for themselves and partners.
32	4.5	Counselling a client with an STI diagnosis
34	5	COUNSELLING BEFORE HIV ANTIBODY TESTING
34	5.1	Helping clients to decide whether to have an HIV antibody test or not
36	5.2	Counselling clients who have decided to have an HIV antibody test
37	5.3	HIV antibody testing that is not voluntary
38	6	COUNSELLING AFTER THE HIV ANTIBODY TEST
38	6.1	The meaning of the test results
38	6.2	Giving clients their HIV Antibody Test Results
39	6.3	Counselling clients with a positive test result
43	6.4	Counselling clients with a negative test result
44	6.5	Counselling when the test result is not clear
44	6.6	Making referrals
45	7	COUNSELLING CLIENTS WHO ARE ABUSED IN SEXUAL RELATIONSHIPS
45	7.1	What is abuse in a relationship?
46	7.2	The Impact of Abuse on Sexual and Reproductive Health
46	7.3	Helping clients to talk about abuse
47	7.4	Ways you can help your client to become empowered
47	7.5	Giving practical help
50	8	COUNSELLING ON THE PREVENTION OF HIV TRANSMISSION TO PREGNANT WOMEN, MOTHERS AND THEIR CHILDREN
50	8.1	HIV transmission from mother to child and methods of prevention
51	8.2	Counselling clients who are considering conception on HIV/AIDS
51	8.3	Counselling pregnant women and their partners
52	8.4	Counselling clients who have HIV infection on PWTC interventions
55	8.5	Helping families with HIV infection to plan for the future
58		RESOURCE LIST

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-Retroviral
CBO	Community Based Organisation
CSW	Commercial Sex Workers
ESEAOR	East and Southeast Asia and Oceania Region (IPPF)
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
NGO	Nongovernmental Organisation
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of HIV Infection to Pregnant Women, Mothers and their Children
RTI	Reproductive Tract Infection
SAT	South African AIDS Training Programme
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZDV	Zidovudine

Integrating counselling on sexually transmitted infections and HIV into Family Planning counselling

1.1 Why should family planning providers get involved in STI/HIV counselling?

There is a great need for effective counselling in STI/HIV

Good counselling is important in helping people with concerns about sexuality, STI and HIV. Many people feel unable to talk about them because of embarrassment or fear of rejection. If they do, they may not receive the emotional support, information and skills they require. Fears about the future, guilt, anger and despair may overwhelm them. They may not feel able to talk to their partner about sexual problems, safer sex or an STI/HIV diagnosis. These situations are complex and clients need time to talk them over and make good decisions.

Family planning counsellors can play an important role in STI and HIV counselling

Family planning counsellors have many opportunities to counsel clients on other sexual and reproductive health issues, including STI/HIV because:

- Counsellors see people who are in sexual relationships and may be at risk of STI/HIV.
- Counsellors distribute male and female condoms, the only methods that protect against STI/HIV.
- Clients need protection from unwanted pregnancy and STI/HIV.
- Clients need to take risk of STI/HIV into account when they make a decision about which contraceptive to use.
- Some family planning counsellors are used to talking about sexual issues.
- Counsellors may talk about gender relations, which affect risk of STI/HIV.
- Counsellors can discuss concerns about STI, including signs and symptoms and refer.
- Counsellors can be aware of the possibility of sexual abuse and support clients.

Counselling on sexual health can improve the quality of family planning services.

Some providers worry that integrating STI/HIV into their family planning programme will have a negative impact on their services. In fact it may improve quality for the following reasons:

- The client is looked at in a holistic way, which helps the client with family planning and sexual life generally. Clients feel that the counsellor cares about them as people rather than contraceptive acceptors.
- The use of existing facilities is maximised because counsellors are already trained, experienced and trusted.
- The counsellor can reach a wider group of clients with unmet needs, including young people, men and those not at risk of pregnancy.
- Having a package of different health services helps to prevent stigma.
- The services may have more access to government and other support services, including traditional healers.

1.2 Planning to integrate STI/HIV counselling into family planning services

There are some differences between counselling on family planning and counselling on STI/HIV, which you need to address in your plan to integrate services.

How will you make the plan?

It is important to use a participatory process in which leaders, managers and staff at all levels explore the costs and benefits of integrating different types of sexual health services into your existing programmes. You then make a joint decision on which services, if any, to offer in relation to local needs and service gaps and your values, identity and resources.

As counsellors, you may feel that STI/HIV counselling is an additional task that reveals problems that are difficult to resolve. You will need to take part in the decision to integrate STI/HIV counselling, given a chance to express your fears and to identify your support needs.

People may see family planning clinics as places where 'respectable' married women go for contraception, to do with fertility, not talking about a potentially fatal disease passed through sex. You may fear that the change of image will drive away clients.

What will be included in the service?

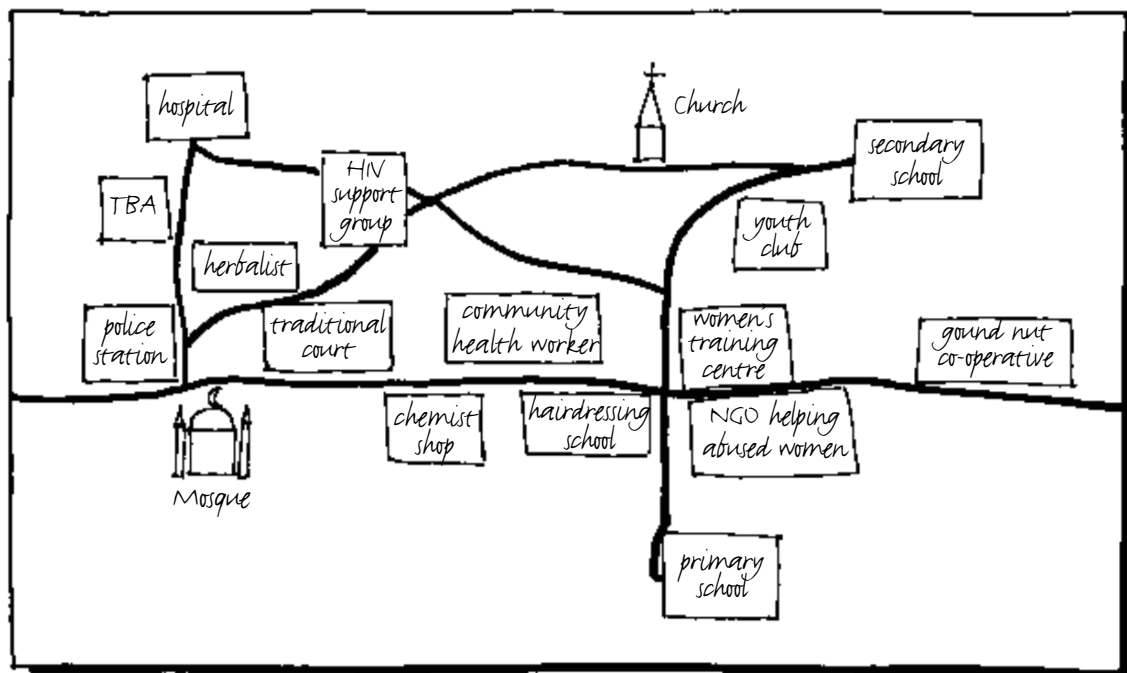
Your organisation needs to decide which types of counselling you will offer. You might decide that

your organisation is best suited to providing STI/HIV prevention counselling and refer clients who need more specialised services. If there are gaps in local services, you might wish to provide a new service, such as prevention of HIV in women and transmission to children (PWTC).

What else will you need to do?

HIV is both a medical and a social issue. Counsellors need knowledge of these issues and contacts with the family and community to address them.

There is more stigma, judgmental attitudes and secrecy around STI/HIV than family planning. This makes it harder to talk about openly and the consequences of disclosure more difficult. Counsellors have limited ways to help clients with these issues. It is important to work for changes in attitudes towards STI/HIV, perhaps by collaborating with other organisations. You need knowledge of available resources for STI/HIV prevention, support and care in your locality. Draw a map of all the resources in your district and use it to refer and collaborate.



Who will you counsel?

Offer all your existing clients the opportunity for STI/HIV prevention counselling. You might make your services more accessible to groups who are also vulnerable to STI/HIV, such as young people, men or single women. You may need to change your image and organisation to attract these groups and provide them with confidential, acceptable services. If couples agree, it can be helpful to counsel them together. This can build trust, help them to communicate more easily and make joint decisions about HIV testing and safer sex options.

Who will do the counselling?

People who are motivated to counsel are more likely to make good, empathetic counsellors. Managers should only give counselling duties to providers who feel committed to it. You need to:

- Train existing service providers.
- Re-organise clinics to make better use of staff time.
- Recruit new staff and/or volunteers.

Lay volunteers are often trained in HIV counselling to fill the gaps in provision. You need to:

- Integrate the work of volunteers into that of other health workers.
- Consult them about ways to maintain their motivation.
- Give agreed rewards for the time and energy that they devote to a difficult task. In poor communities this should usually include material rewards.
- Design training courses that are tailored to meet the specific needs of the volunteers.
- Give frequent refresher training to update knowledge and skills.
- Provide practical items for example, notebooks, condoms, penis models, and leaflets.
- Respect and value the work of the volunteers and acknowledge their generosity to others.
- Arrange frequent meetings with volunteers to share achievements and problems, build support.

What training will they need?

Counsellors need adequate training on all aspects of sexuality and STI/HIV counselling and supervised practice and support. They may not have covered sexuality, STI/HIV and gender relations adequately in previous training or may not have applied the training.

Helping people to adopt safer sex practices may be more difficult than helping them to use contraception if it involves both partners in life style changes and requires discussing intimate sexual practices. You may need to spend time on relationship issues and enhancing clients' assertiveness and communication skills.

Topics need to cover basic information about STIs and HIV/AIDS, transmission routes, risk factors, possible and available interventions, pre and post HIV antibody test counselling and prevention counselling.

Counsellors may need new knowledge and skills, for example, on interventions to reduce HIV transmission from pregnant women to children.

Health care workers may have had little training in HIV/AIDS care and may have similar attitudes to community members. Some issues, such as the benefits of replacement feeding, will contradict previous advice.

Counsellors will need time and help to explore their own attitudes to sexual issues and how these may affect their counselling. This presents new challenges in being tolerant and talking about perhaps disapproved sexual practices.

What support will they need?

Managers must acknowledge the importance of counselling on STI/HIV for their organisations, appreciate the staff who do this and allow them sufficient time to counsel.

Many counsellors experience stress as a result of counselling on HIV. Managers need to provide regular support to minimise "burnout" and avoid losing valuable staff.

Counsellors need to regularly change their tasks and have breaks from HIV counselling and also have access to counselling themselves.

Discussing HIV may raise personal anxieties for providers and may affect their ability to counsel others. Confidential counselling support and testing should be available.

Language barriers may be a problem which confidential lay interpreters can help with.

Knowledge of HIV/AIDS is changing fast. Counsellors need to keep up to date to provide accurate information to clients, for example by updates from local HIV experts and the internet.

Where and how will counselling be carried out?

You may need to change the organisation of your clinic to enhance privacy and client flows to enable young people and men to access the services. Some clinics have little time for counselling each client. There are a number of solutions to this problem:

Move out of the clinic

The clinic may not be the best place to counsel, particularly for clients for whom sexual activity is not approved. Community-based counsellors can meet people privately in a suitable place and provide more relaxed and accessible counselling.

Group information-giving

Group information-giving can help to provide more people with knowledge but counsellors still need to check that clients understand the facts in relation to their own lives. Between ten and twenty people in a group gives opportunities for discussion. You will need to:

- Warn the group that you cannot guarantee confidentiality and it is safest to talk about issues in a general way rather than disclose personal information. This can happen later in the individual counselling sessions.
- Give the basic facts about HIV/AIDS, transmission routes, what the test can tell you, potential advantages and disadvantages of having the test and the process of counselling and testing. Give the information in a clear and interesting way that relates to people's lives. You could use a video or pamphlets to provide the information.
- Ask the group if they have any questions and encourage discussion through the information giving. If you have enough time, have some discussion after each topic.

Group counselling

A group of about ten people who feel comfortable to talk together can discuss things in more depth. For example, single sex groups of a similar age and status, couples or families.

- Explain that people may wish to share their feelings and experiences but they must understand that confidentiality is not guaranteed in a group.
- Build rapport, explore issues around testing, options for risk reduction and coping mechanisms.
- Encourage sharing of successful strategies for safer sex and coping and help people to gain more understanding of their options, the test and their own feelings.

HIV antibody counselling in antenatal clinics

In some countries, HIV testing of all pregnant women is compulsory. We DO NOT recommend this because ALL HIV testing should be voluntary, with women making an informed decision whether to be tested or not after counselling.

Women attend antenatal clinics for the purpose of their own health and the health of their child. They are unprepared for HIV testing and often find it traumatic. They often have no signs or symptoms of STI or HIV and little knowledge about it. Women usually attend the antenatal clinic alone and this can make it very difficult to tell their partner about the test result.

Providers and clients at the antenatal clinic may not be sufficiently aware of the level of confidentiality required in HIV testing. There is little privacy in many antenatal clinics. Therefore:

- Counsel in privacy so that women feel comfortable to discuss sexual risk factors.
- Provide a space where accompanying children can play with supervision.
- Share confidential information about clients with providers to ensure that pregnant women get treatment and support and to reassure providers that they are not being put at risk.
- HIV test counselling and ongoing support takes longer than the usual antenatal interview.
- Giving pre-test information in groups can save time during counselling.

When will it be done and how much time will be needed?

Ideally counsellors should provide services at times convenient to their clients. This may be easier if they are working outside the clinic, in the community.

Counsellors need time to do good counselling on STI/HIV. Pre-HIV test counselling takes at least 30 minutes and post-test counselling after a positive result may take more than an hour and need to continue. Managers must recognise the time needed and plan accordingly.

What additional resources will you need?

Consider human, material and financial resources carefully and realistically before making decisions about what type of counselling to offer.

Family planning and other local services may not have resources such as drugs needed to help clients who test HIV positive or have a STI. You need to tailor counselling to available resources, seek funding before starting or form partnerships with other organisations.

1.3

What ethical and legal issues will you have to address?

Legal issues

There may be a range of legal issues in your country, for example:

- Parental consent may be needed to counsel young people.
- Homosexuality may be illegal.
- Termination of pregnancy may be illegal.

Ethical Issues

Ethical issues might include:

- Confidentiality issues around sexual partners, relatives, healthcare workers etc. Who has a right to know about a person's HIV status and who needs to know in order to help the person and their partner(s)?
- Health insurance companies demanding to know HIV status of clients.
- Workplaces who do compulsory testing for a visa or employment.
- Religious bodies demanding the couples have an HIV antibody test before marriage.
- Social discrimination when people learn that someone has tested HIV positive.
- People fired from their job because of their HIV positive status.
- Some countries carry out involuntary sterilisation of people who are HIV positive.
- Some religions do not accept the use of contraceptives, including condoms and harass or stigmatise those who distribute them or use them.

Organisations need to agree on policies to address these legal and ethical issues and disseminate

them throughout the organisation. These might include advocacy for new laws and policies to prevent discrimination; educating people about laws and human rights agreements already in place and education aimed at changing negative attitudes.

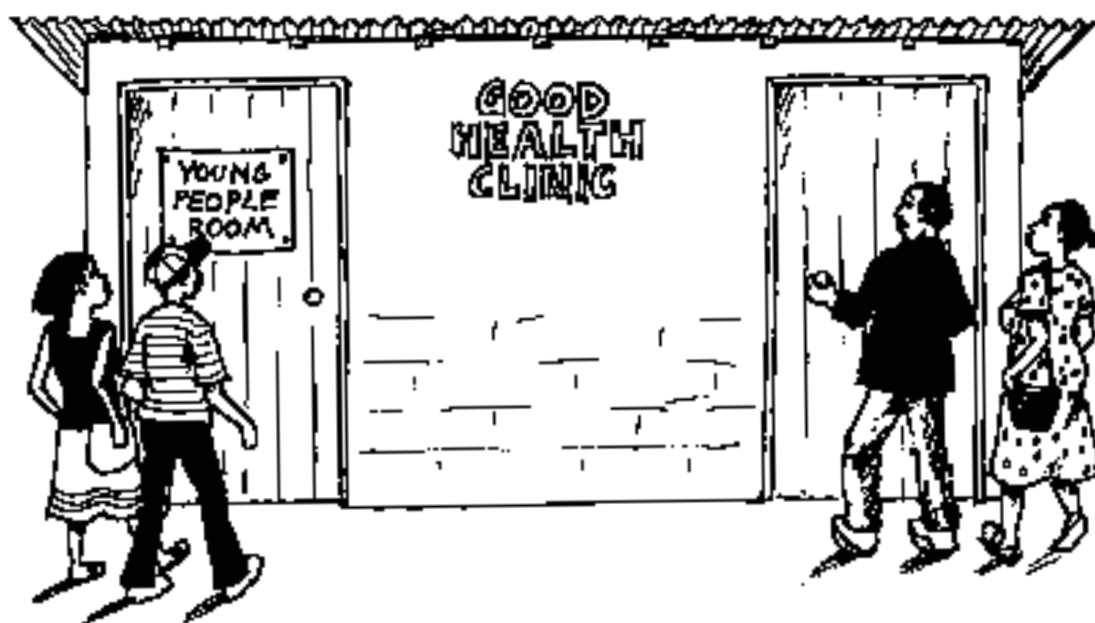
1.4 Specific issues for clients in different situations

This section provides some pointers on common issues for counsellors working with different groups in various cultures. You need to learn about your local situation by listening to clients and learning from groups in the community as well as through reading, the internet and collaboration with specialist agencies. We list some useful resources at the end of the Guide.

GROUPS	ISSUES	COUNSELLING IDEAS
Children	<ul style="list-style-type: none"> ■ May have been sexually abused by relatives, friends of the family or others. ■ Infected/affected by HIV/AIDS. 	<ul style="list-style-type: none"> ■ We have not addressed this topic because of the need to cover it comprehensively. See resource guide.
Young people	<ul style="list-style-type: none"> ■ Have difficulty in accessing information and services for sexual health, including protection from STI/HIV and pregnancy. ■ Keep sexual activity secret due to societal norms, resulting in unplanned/unsafe sexual activity. ■ Their inexperience makes safe decisions more difficult. ■ Their feelings and sexual relationships may be more important to them than safety. ■ Condoms may be too large, not affordable or accessible for them. <p>Issues for young men: May be under pressure to prove manhood by becoming sexually active, having many partners or using commercial sex workers.</p> <ul style="list-style-type: none"> ■ Sexual experiences may have been with other males. <p>Issues for young women: In some places they are six times more likely to contract HIV than young men because:</p> <ul style="list-style-type: none"> ■ of their physiological vulnerability. ■ Lack of power and negotiation skills for safer sex. ■ May be pressured to have sex with an older man or marry early. ■ May have to exchange sex for money or goods. 	<ul style="list-style-type: none"> ■ Set up accessible services. ■ Hold sessions for young people at a special time or in a particular space. ■ Train peer counsellors to counsel and provide information to young people and welcome them at the clinic. ■ Attract young people with videos, games and educational discussion groups. ■ Do not show disapproval of lifestyles or sexual practices. ■ Encourage young people, especially those under the age of 16, to talk with their parents or a trusted person about their sexual and reproductive health concerns. ■ Help young people to make their own plan for reducing their risk of HIV infection. ■ Help them to see abstinence as a positive option. ■ Find ways to make condoms accessible to all young people who need them. ■ Set up support groups for young people who are living with HIV. ■ Provide sexuality and life-skills education or collaborate with agencies who do. ■ Work to change harmful practices, for example with a programme like 'Stepping Stones' which helps the community to analyse the cultural and other factors influencing sexual health. See resource list.
Men & women	<p>Married couples</p> <ul style="list-style-type: none"> ■ Risk of STI/HIV infection due to unprotected sexual intercourse outside marriage. ■ Wives may not have sex if they are menstruating, breast feeding, abstaining to space birth or ill. ■ Men may not have sex with their wives because they are impotent, ill, have too many wives, wish to punish them or have girl friends. 	<ul style="list-style-type: none"> ■ Counselling and the provision of condoms and contraception can help married couples to stay with each other, because they are able to have sex whenever they wish. It can also enable married people to avoid HIV infection with outside partners.

GROUPS	ISSUES	COUNSELLING IDEAS
<p>Men & women cont.</p>	<p>People living together as sexual partners</p> <ul style="list-style-type: none"> ■ May have more frequent changes of partners because the man or woman can more easily leave the relationship. ■ If this behaviour is culturally unacceptable or illegal, it is more difficult to access information and services and this increases their vulnerability to STI/HIV. 	<ul style="list-style-type: none"> ■ Find ways to make your services more accessible to cohabiting people and every man and woman of any age who is sexually active outside marriage. ■ Accept these clients and do not judge them.
<p>Men away from home</p>	<p>Men away from home such as migrants and truck drivers are at high risk of HIV.</p> <ul style="list-style-type: none"> ■ Suffer from loneliness and miss social controls from home. ■ May form peer groups who express their solidarity by drinking and having many partners. 	<ul style="list-style-type: none"> ■ Find ways to reach men away from home. They may be a mobile group or may live in hostels together. ■ Peer educators and counsellors at the work place, hostels or rest stop can help men to talk about HIV, condom use and consider testing or invite the services to come to an acceptable venue.
<p>Commercial Sexworkers (CSWs) & people who exchange sex for goods</p>	<p>Women and men may exchange sex for goods, money and favours regularly or when times are hard.</p> <ul style="list-style-type: none"> ■ Difficulty in negotiating safer sex depending on neediness and if clients pay more for unprotected sex or clients are violent and drunk. ■ CSW's may use condoms in commercial situations, but not in intimate relationships. This may increase the risk of STI/HIV infection from their partners. 	<ul style="list-style-type: none"> ■ Help CSW to build their assertiveness and negotiation skills. ■ Assist CSWs to earn some extra income through other enterprises so that they are more able to refuse unsafe clients. ■ Find ways to make your services accessible to CSW, by being non-judgemental or through peer counsellors. ■ Work with men and those involved with CSW such as pimps, landlords and police so that they accept condoms.
<p>Sexual relationship with a person of the same sex</p>	<p>There are strong taboos about same sex activity, although it occurs in every society.</p> <ul style="list-style-type: none"> ■ People may engage in sexual activities with someone of the same sex without identifying themselves as homosexual or bisexual (having sex with men and women). ■ Same sex activity is stigmatised and illegal in many countries, resulting in a lack of information, services and support. ■ Secrecy may lead to unstable relationships and hurried and unprotected sexual encounters increasing the risk of HIV transmission. 	<p>There may be laws against homosexuality in your country but at the same time human rights laws against discrimination, which apply whatever the person's sexual orientation. Find out how you can use these laws to provide services to and protect people who have sex with people of the same sex.</p> <ul style="list-style-type: none"> ■ You need to accept sexual activities between people of the same sex and recognise that it is more common than most people think. ■ Never assume that your clients only have sex with the opposite sex. Give them opportunities to talk about same sex activities.
<p>Drug Users</p>	<ul style="list-style-type: none"> ■ People in most societies use mood-altering substances to make themselves feel good, for example, alcohol, cannabis, quat and heroin. ■ Drug abuse happens when people can no longer control the frequency and 	<ul style="list-style-type: none"> ■ Strategies to prevent drug use and cure addicts have not been very successful so the main strategy now is to achieve harm reduction in drug users. ■ Find out about any referral centres for drug abusers in your area and refer people.

GROUPS	ISSUES	COUNSELLING IDEAS
<p>Drug Users cont.</p>	<p>amount they take and the drug damages them physically, mentally and socially.</p> <ul style="list-style-type: none"> ■ A person who mentally finds it difficult to refuse a drug is dependent. A person whose body needs the drug is addicted. Addicts suffer from severe withdrawal symptoms when they stop taking the drug and find it very difficult to stop altogether. ■ Drugs may lead to unsafe sex because people find it more difficult to think about safer sex and use condoms successfully. ■ Some people put drugs such as Mandrax into drinks to drug people and rape them. <p>Injecting Drug Users</p> <ul style="list-style-type: none"> ■ Injecting drug use is a major mode of HIV transmission in some parts of the world. Injecting drug users (IDUs) are at very high risk when sharing injecting equipment that contains contaminated blood because the HIV is injected directly into the blood stream. ■ IDUs may have increased sexual risk behaviour as they forget about condom use when they are high. 	<ul style="list-style-type: none"> ■ When you are counselling people on safer sex, explore their use of drugs and how this might put them at risk. ■ Discuss ways to reduce the risk with them. This may involve not going to places where drugs are used, limiting the amount taken or having a plan to avoid sex or practice safer sex at these times. ■ Work with clients to find strategies to protect themselves and challenge their behaviour <ul style="list-style-type: none"> ■ Find ways to reach IDUs to areas where they spend time and provide them with information and counselling on safer needle usage and safer sex. ■ Encourage them to visit places which provide free needle equipment and help with addiction.
<p>Health care workers</p>	<ul style="list-style-type: none"> ■ May be at risk of HIV infection through needle prick injury, direct exposure to body fluids on mucous membranes or breaks in the skin. For example, amniotic fluids splashing into eyes during delivery. ■ May be anxious about exposure to HIV. 	<ul style="list-style-type: none"> ■ Health care workers need access to counselling, post exposure prophylaxis if necessary and help in making a plan of action to reduce their risk, with support from managers and other staff. ■ Need access to protective clothing and safe practices when using sharp instruments and needles.



Try to make your services accessible to all groups

2.1 What is Counselling?

Counselling is about creating new perspectives and change. The change may be inside the person (helping them to feel differently about a situation) or a change in their behaviour (for example, practising safer sex) or a change in their environment (for example, setting up a support group).

Counselling aims to help people to:

- Understand their situation more clearly
- Identify a range of options for improving the situation
- Make choices which fit their values, feelings and needs
- Make their own decisions and act on them
- Cope better with a problem
- Develop life skills such as being able to talk about sex with a partner
- Provide support for others whilst preserving their own strength.

Counsellors establish partnerships with their clients, with both as active participants. Counsellors take an active role in making this happen by encouraging clients to talk about their own thoughts about issues such as safer sex. They explain that counselling is a collaborative process and the client has the responsibility for making decisions and choices, with the counsellor's help. They seek agreement from their clients by asking:

“would you like us to work together to sort this out?”

Counselling is different from providing a medical service where providers generally give treatment, health information, advice and instructions to service users.

This partnership model means that attitudes are very important in counselling.

2.2 What attitudes do counsellors need?

Your attitudes as a counsellor are very important. Sexuality is a sensitive subject and unless you show your clients that you care about and respect them, they will not be able to talk openly about their lives and feelings.

As a good counsellor you should have the following characteristics:

- Be interested in clients as people, not as a medical problem.
- Be aware of your own feelings and values. Do not judge clients, moralise or impose your own values on them. Do not allow religious beliefs to interfere with helping clients to explore all their options, even if you personally do not agree with them. Do not show disapproval in your words or body language.
- Be warm, approachable and easy to talk to and respect your client.
- Use empathy to make clients feel supported. Try to understand a situation from the client's point of view and express a caring response. For example, *“That must have been very difficult for you to go through”*. Empathy gives clients strength. This is different from sympathy, which is expressing pity for the client, feeling sorry for them and linking the client's situation into your own feelings and problems. Sympathy can weaken clients and make them feel helpless.
- Recognise clients strengths, knowledge and resources to cope with their problems. Do not feel superior to the client. Be open to learn from the clients as they know more about their lives.
- Respect clients' different ideas on health and understand that we all have a mixture of 'scientific' and more local knowledge about our bodies and health.
- Be sensitive to inequality between males and females and how this may affect sexual health.
- Be aware of your own gender biases.
- Be impartial and objective and do not impose your own opinion on clients.
- Be honest and trustworthy. Provide accurate information and do not falsely reassure clients.
- Maintain confidentiality and never discuss clients with others.

- Be compassionate and patient. Do not rush clients but give them time to consider their situation and make a decision when they are ready.
- Be concerned with upholding rights. For example, never try to persuade or advise a client to have an HIV antibody test or do it without informed consent.
- Be committed to clients' well-being and do everything you can to support them. Be positive and offer hope.
- Know your limits and when and where to refer clients for additional help. Do not try to solve every problem for the client but use your particular skills to help the clients solve their own problems.
- Be willing to learn continuously, even from your mistakes, so that your counselling becomes increasingly helpful to clients.
- Be ready to be counselled yourself. This is particularly important in relation to sexuality because many of us do not have the opportunity to reflect on our own sexual lives. Learn to negotiate yourself before you provide negotiation skills for others.
- Know different cultures. Be aware of cultural differences and ask for a fuller explanation if you do not understand or need to know more.



Know yourself and deal with your own problems

2.3

What skills does a counsellor need?

Anyone can develop and use counselling skills to improve the way that they relate to clients. Some of the most important skills for a counsellor are verbal and non-verbal communication skills. One third of communication is understood through words and two thirds through body language. Body language includes our facial expression and how it changes as we communicate; how we sit in relation to the client and gestures such as nodding. As a counsellor, you need to do the following:

- Establish a relationship with your client to allow free and open interaction.
- Establish a partnership where you and your client are both active participants. Engage and work with your client. Take an active role in creating the partnership.
- Show clients that you are listening to them actively. Use appropriate body language such as eye contact, sitting in a relaxed position, nodding, using suitable verbal responses such as “mmm, I see, ...”
- Listen to your client's verbal and body language. Clients value time spent listening to them. This can be more important than the listening done by friends and family.
- Listen to your client's language and adapt your language to meet theirs, without mimicking them. Listen for key words, which indicate important issues for the client. Pay attention to what your client is telling you.
- Acknowledge and validate your client's story.
- Do not write and listen at the same time. Give your full attention to listening and then make notes with the client's permission if necessary.
- Check that you have understood your client by repeating what they have said in your own words (paraphrasing) or summarising what you heard.
Say: “As I understand it, this is what has happened so far, is that right?”
- Check that you have understood their feelings by reflecting them back to the client:
Say: “You seem to be feeling very angry with your partner, is that right?”
- Give the client enough time to express their ideas and to make their own decision.
Value silence while the client thinks deeply or copes with emotions.

- Simple and straightforward questions help clients to talk freely and explore their situation in depth. Use open-ended questions such as ‘*can you tell me more about your family?*’ that encourage clients to talk more freely than closed questions, which have a “yes” or “no” answer. Probing questions, such as “*Could you tell me more about that?*” are also helpful. Ask one question at a time and give the client plenty of time to answer.
- Clarify what your client has said by asking for more information or an example:
 - “*I am not sure that I understand – could you explain it further?*”
 - “*You say that your husband gets easily annoyed about small things. Could you give me an example?*”
- Be knowledgeable about the issues concerning the client. Give full, correct, accurate, honest and clear information as it is needed in ways that are relevant to the client. For example, through drawings or local explanations of the world. Do not give false reassurance.
- Build on clients’ strength. Clients have abilities that they may not be aware of because of the difficulties they are facing. Ask what your client has been able to do about the problem, what worked and what didn’t and why it did not work and then help the client to make an action plan. Avoid making the client dependent on you.
- Provide some new ways of looking at a situation and some new options. For example, provide information about a service or a range of safer sex activities.
- Challenge the client to see things more clearly. For example, a male client may believe that forced sex within marriage is normal and does not harm anyone. You can challenge him to imagine how the woman might feel and what the physical and emotional consequences might be.
- Help clients to look into themselves and understand their feelings, motivations and behaviour more clearly. For example, many women deny anger that they feel towards their partners because they feel it is not a proper feeling. Once they (and their partners) are able to recognise the anger and its causes, they can begin to deal with it and improve their relationship.
- Help clients to make their own decisions by helping them to look at the good and bad points of each option, likely outcomes and how they match their values. Do not give advice or try to persuade, convince or motivate them to take a course of action.
- Help the person to focus on priority issues where they can achieve some positive change, rather than being overwhelmed by the whole problem.
- Help clients to identify others that they can rely on and receive help from. This might include the family, church, friends, support groups, primary health care providers, social welfare, police and the courts, and local non-profit NGO and CBOs. Be knowledgeable about available referral networks for all the diverse needs of the client and his or her partner and/or family.
- Check that you have understood the client’s situation when you begin again from a previous session; at the end of a session; when taking a break or when moving to a new issue or subject.
- Provide ongoing support as needed and wanted by the client.

2.4

The Counselling Process

There are several models of counselling where you can use your counselling skills. **GATHER** is one that is often used in contraceptive counselling.

Greet your clients
Ask your clients why they have come and about their situations
Tell your clients how you can help them
Help your clients to make their own decisions
Explain how to use the methods they have chosen
Return visits are arranged to see how they are getting on.

This model was designed for contraceptive counselling, but you can adapt it for STI/HIV. **REDA** is another model, which is more open and flexible.

Response is developed between counsellor and client
Explore the problem, situation and options for change
Decide on the best option
Act on the decision

Preparing for the counselling session

Prepare yourself for the session. Gather relevant educational materials, find out about or remind yourself of the client's history if she/he has been before, prepare yourself to break possible bad news and assess your strengths and limitations.

How to start a counselling session

Greet your client(s), introduce yourself and give the client time to settle down. Make sure that there are no physical barriers or distractions between you and the client.

Assure the client of confidentiality, this is one of the most important values in your relationship.

Begin to establish a partnership with your client. Find some common experience, which you can share and become closer.

- Do not assume that you know why the client has come, unless it is for an agreed and specific purpose like an HIV antibody test result. Ask an open question to encourage the client to tell his/her own story. For example,
“What brings you here today?”
“Where would you like to begin?”

- Do not assume that the client has only come for one issue. Check if there are any other issues by asking:
“Is there anything else on your mind?”
“What else has been happening?”

If you do not understand all the issues, the client may say as she/he is going out of the door “oh and by the way...” and then you will have to start all over again if you have the time.

- The presenting problem may not be the most important one. For example, the client may ask to have the Intrauterine Device (IUD) removed but she is really worried about HIV infection. Help the client to talk about the presenting problem in depth to find out about the problem behind it.
“Could you explain to me why you want to have the IUD removed?”
“Are there any other reasons?”

- Explain that counselling is a collaborative process in which your client has the responsibility for making decisions and choices, with your help.
“would you like us to work together to sort this out?”

- Discuss and agree on priorities when there is more than one problem. Identify the most important problem that your client wants help with today and check that your understanding is correct.
“As I understand it, the most important problem that you want to talk about today is...”

- Ask the client what she/he is hoping to achieve at the session today and agree with her/him on a realistic expectation.

- Summarise and reflect on the main points in the conversation.

- Check the match between the verbal and non-verbal communications of your client and yourself.

- Negotiate and set the agenda and agree on how much time you have together.

How to continue a counselling session

- In this phase, analyse and work on the problems together in more depth, look at options for solving them, assess the pros and cons of each and help the client to come to a decision.

- If appropriate help the client to express her/his feelings, which often makes her/him feel better and find ways to cope with them.

- Help the client to build on her/his knowledge, skills and self-esteem. Provide practical information, as it is needed.

- Seek out the client's ideas, ask:

“What ways can you think of to address this problem?” “What are the good and bad points about this option?”

Use the client's ideas as much as possible and provide new perspectives and additional information.

“If you follow this course of action, what do you think will happen? What might go well and what problems might you have?”

“If that happens, what will you do to avoid or cope with it?”

How to end the counselling session

- Towards the end of the session, point out that the session is nearly at an end, or say:
“I feel that we have got as far as we can today – what do you think?”
- Ask your client where she/he thinks you have reached in the session, what she/he will do next and what support she/he needs to achieve the next step.
- Go over the next steps with her/him and find out what support is needed after the counselling session.
- Arrange a follow up session if necessary.
- Refer her/him to support groups or other agencies if appropriate.
- Ask if there is anything else she/he wants to say before the session ends.
- Praise the client for her/his active work to sort out the problem and contributions to the session.

Aims

- To help clients to express their sexuality safely and enjoyably in ways that feel right to them and understand the factors that affect sexual pleasure.
- To help clients talk about their sexuality, sexual activities, intimacy and relationships.
- To help clients to feel confident and accept their own sexuality, sexual desires and functioning.
- To explain that everyone has the right to pursue sexual happiness but only where the happiness and health of others is not at risk.
- To help clients to express their feelings, needs and concerns about sexuality with partners and to negotiate for safer sex.

3.1 Counselling on sexuality and sexual expressions

Talking about Sexuality

KEY FACTS

- Sexuality is more than sexual behaviour and sexual intercourse. It includes social roles, personality, gender and sexual identity, biology, relationships, thoughts and feelings.
- Sexuality has changing significance for people in various stages of life. Sexuality is affected by age, gender, culture and sexual orientation.
- The expressions of sexuality are influenced by various factors including social, ethical, economic, spiritual, cultural and moral concerns.
- People find it difficult to talk about sexuality and often only accept it when there are important reasons, such as protection from STI and HIV. People need to accept their own sexuality and communicate about it if they

are to assess and reduce their risk of STI/HIV infection.

- Many clients would like to talk to their counsellor about their sexual relationships and intimacy. They may feel that this is the only person with whom they can share their feelings about sexual relationships and STI and HIV, without fear of discrimination.
- Sexual orientation refers to primary sexual attraction to the same, opposite or both sexes.
- Most societies find it hard to acknowledge and accept that homosexuality or bisexuality are a universal part of human sexuality. Many gays, lesbians or bisexuals neither experience nor desire a choice in their sexual orientation.



- Sexual behaviour refers to sexual activities that people engage in. For example, a married man may have sex with men sometimes as well as his wife, but not identify himself as homosexual.
- Counselling aims to create a climate where all clients can express themselves without fear of discrimination.

Sexual pleasure

KEY FACTS

All people, whatever their HIV status, have sexual feelings and may need help to feel able to express those sexual feelings safely and happily.

- Sexual pleasure depends on a variety of factors, including mood, where and why people have sex and what society feels is appropriate or not appropriate behaviour.
- Sexual satisfaction rises when there is more intimacy between the partners. Understanding and accepting our own sexual desires and those of our partner helps to build intimacy, as well as being close in non-sexual ways.
- Cultures differ greatly in how they view

different types of relationships and sexual activities. Women are usually expected to follow stated rules more than men.

- Everyone has the right to pursue sexual happiness in their own way, but only where the happiness and health of others is not at risk.
- Forced sex is wrong. No one has the right to have sex with a partner if it degrades her or him to an impersonal object. Everyone has the right to say no to sex at any time.
- Sexual pleasure need not be limited to sexual intercourse.
- Counsellors need to be aware of the most common physical and emotional problems clients may have with sex.

Issues to explore with your clients

Reflect together on giving and receiving sexual pleasure by exploring the client's personal experiences with sexual pleasure. Explain how their own and their partner's body functions. Discuss personal and social contexts for sex and factors like place, time, and frequency.

Explore the factors that affect the clients' sexual pleasure. What are the situations where sex is very enjoyable and where it is not? What are the reasons for this?

Explore what sexual activities clients enjoy and prefer and give information on activities that clients may not have thought of.

Unsafe sex might be very pleasurable for clients. Discuss safer sex not only in terms of STI, HIV and pregnancy prevention, but also explore ways to make safer sex pleasurable.

Enable clients to talk about same sex activities or more than one sexual partner even if they are married. Do not make any assumptions about their sexual behaviour.

Be aware that sex may not be pleasurable or consensual for your client. Explore the relationship between gender relations and sexual pleasure.

Sexual empowerment

KEY FACTS

- It is important for counsellors to be aware of how gender roles and stereotypes influence sexual relationships. The inequity between men and women is reflected in sexual relationships, making both women and men vulnerable to STI/HIV.
- There are often double standards on sexual activity. Women are expected to abstain from sex before marriage and be faithful in marriage, whilst men are 'allowed' or expected to be sexually active before marriage and to have sexual relations outside marriage.
- In many societies, men are socialized to treat women as inferior in order to exercise power over them. Sexual acts do not always take place between two consenting adults, but involve domination of one person by another. Women and young people may not have the right to refuse sex if their partners or an older person asks for it.
- Disagreement over the use of preventive methods can lead to abusive situations. Men may feel that the prevention of unwanted pregnancies and even STI/HIV is a female concern. On the other hand, women who carry condoms or use contraceptives may be accused of promiscuity. This results in conflicts with men demanding unprotected sex but expecting women to protect themselves.
- The sexual pleasure of men is often considered more important than that of women. Women are seen as providers and men as seekers of pleasure. Women may be accused of promiscuity if they ask for or obviously enjoy sex. Ignorance and lack of communication about sex may contribute to this problem. Men and women may not know about the importance of the clitoris for female pleasure or that women can have orgasms.

KEY FACTS

cont.

- In some cultures, women are expected to have dry tight vaginas to please their partners. A sexually aroused woman is thought to be 'loose' or to have an STI. This practice puts them at risk of STI/HIV because the vagina wall easily tears and condoms are more likely to break.
- Some women undergo genital cutting, which can involve the removal of the clitoris and labia and closing of the opening to the vagina to a small hole. This makes sex painful and the trauma and bleeding put these women at higher risk of HIV. This practice is believed to preserve chastity and fidelity and gives men more control over women.
- National laws may promote greater equity between men and women and positive sexual and reproductive health practices. These laws may be different from local norms related to culture, religion and class. The law may state that girls should not marry until they are 18 years old, but local culture promotes marrying girls after puberty to avoid premarital sex.
- Universal human rights and sexual and reproductive rights include the right to life and to bodily integrity and making our own decisions about sexual activity, marriage and having children.

How can counsellors help clients to empower themselves?

- Explore clients' opinions about gender inequalities in sexual life and challenge them.
- Help clients to understand the impact of gender inequality on their sexual lives and health and look for ways to change them.
- Collaborate with other organisations and groups in your area who are working to change gender norms, improve gender relations and make them more equitable. Explore the origins of harmful practices with male and female clients, and their advantages and disadvantages. Challenge clients to have a new perspective on them.
- Educate clients about laws and universal rights and seek ways to put them into practice.
- Counsel men and women separately, in couples, and in small single sex or mixed groups so that they understand the views and feelings of the opposite sex. Show images of responsible, caring and assertive men and women.
- Provide information on male and female sexuality and sexual response to enhance mutual sexual pleasure. Include this in local ways of socialising young men and women on their gender and sexual roles. You can help circumcised clients to explore alternative routes to intimacy and sexual pleasure if the partner is caring.
- Help clients to know their rights and practice assertiveness and negotiation skills through role-play.

Aims

- To help clients to assess their own risks of HIV infection and STI in the past, now and in the future and to make a plan to reduce risks.
- To help clients, whatever their HIV status, re-think their sexual lives and find ways to enjoy safer sex.
- To help clients to feel positive about male/female condom use.
- To identify clients who have a Reproductive Tract Infection (RTI) or STI so that they can receive prompt treatment and prevent (further) infection in partners.
- To help clients to take RTI/STI treatment correctly.
- To help clients with STI to inform all their partners of the need to go for check up and treatment.

KEY FACTS

- HIV, the human immune-deficiency virus which causes AIDS (Acquired Immune deficiency Syndrome) is found in blood, semen, vaginal fluids and breastmilk. It can spread from one person to another through vaginal, anal or oral sex; blood transfusions; unsterilised needles or instruments and from mother to child during pregnancy, delivery or breastfeeding.
- HIV is transmitted more easily in a person with an STI. The prevention and prompt treatment of STI reduces HIV infection by nearly 60%.
- There is currently no cure for HIV infection, although treatments are available to slow down the progress of HIV infection. HIV remains in the body after infection for life and may cause no signs and symptoms for many years.
- Signs and symptoms which may indicate HIV infection and AIDS include weight loss greater than 10% of body weight; fever or diarrhoea for more than a month; persistent severe fatigue; cough for more than a month; itchy skin rashes, cold sores, shingles, thrush in the mouth and throat and swollen glands at 2 or more sites for more than 3 months. A positive HIV test is needed to diagnose HIV Infection or AIDS because other illnesses have similar signs and symptoms.
- STIs are caused by viruses, bacteria or protozoa, which are sexually transmitted through vaginal, oral or anal intercourse. Only HIV and hepatitis may also be passed through blood transfusion and injections. Some STI, for example, herpes can be transmitted by kissing and body touching.
- STIs are a common problem in many parts of the world, even where HIV prevalence is low. Common STIs include gonorrhoea, chlamydia, syphilis, chancroid, herpes and pubic lice.
- Signs and symptoms of STI include: sores on the genitals, anus or lips, which may be painful or painless; unusual discharge from the penis or vagina, which may smell bad; burning pain on urination; itching, burning or soreness in genitals; lower abdominal pain; pain when having sex; unusual bleeding which is not a period and chills and fever.
- STIs are serious because they can cause pelvic inflammatory disease, ectopic pregnancy, infertility, damage to unborn and new-born children, illness and death.
- STI's can progress more quickly and severely in people with HIV and may present slightly different symptoms.
- Some STI remain in the body without causing symptoms but can be transmitted to partners and unborn children and cause illness in the future. These include Syphilis, hepatitis, herpes and chlamydia.

4.1

The risk of STI/HIV transmission in different sexual activities

There are many different sexual activities that men and women, men and men or women and women may engage in to express their sexuality. Sexual intercourse involving penetration is only one of these, there are many more.

When you help clients to assess their risk and make a risk reduction plan, you need to help them to talk about what activities they engage in. In this way, your clients will be aware of the risk level of all potential activities and have many pleasurable possibilities to consider.

The list of activities in the boxes below is not complete – add others that you know about and ask your clients if they have any others.

SAFE SEX	SAFER SEX	UNSAFE SEX
<p>These are sexual activities (SA) with no risk of HIV transmission.</p> <ul style="list-style-type: none"> ■ All SA between two uninfected people are safe. ■ All SA that do not and could not involve semen, vaginal fluids or blood going from one person into another are safe. 	<p>These are sexual activities (SA) with a low risk of STI and HIV transmission.</p> <ul style="list-style-type: none"> ■ SA involving a person with HIV infection where there is no semen, vaginal fluid or blood going from one person into another. ■ Activities that are theoretically safe at this time and are not known to have been a route for infection. 	<p>These are high-risk sexual activities.</p> <ul style="list-style-type: none"> ■ Any practice with a person who might have HIV infection that allows blood, semen or vaginal fluids inside the body through the mucous membranes of the mouth, vagina, penis or anus or through broken skin.
<p>These include:</p> <ul style="list-style-type: none"> ■ Massage ■ Hugging ■ Solo masturbation ■ Body to body rubbing (not genitals) ■ Sex talk, sexy dancing ■ Sharing sexual fantasies ■ Body kissing ■ Showering together ■ Using sex toys without sharing them. 	<p>These include:</p> <ul style="list-style-type: none"> ■ Masturbation of each other if there are no cuts on the hands and people don't touch their own genitals afterwards. ■ Open mouth kissing if both partners have no bleeding gums or cuts in the mouth. ■ Vaginal intercourse with a condom. ■ Gentle anal intercourse with a condom and plenty of water-based lubricant. <p>✗ HIV and Oral Sex – see below.</p>	<p>These include:</p> <ul style="list-style-type: none"> ■ Vaginal and Anal intercourse without a condom ■ Any type of blood contact, including menstrual blood, semen or vaginal fluid entering breaks in the skin. ■ Sharing sex toys without cleaning them between partners ■ Any type of sex that damages the delicate tissues in the vagina, head of penis or rectum. For example, dry sex, rough sex, abrasive substances in vagina.

✗ HIV and oral sex (mouth to genital contact):

Research has shown that it is possible to transmit HIV through oral sex, but cases where this has happened are rare. As far as we know receiving oral sex appears safer than giving oral sex. The risk of HIV transmission through oral sex is greater if the person or partner has an untreated STI such as gonorrhoea or syphilis. Untreated STIs are easily transmitted through oral sex.

- Oral sex on a woman. This is risky during a menstrual period or when the person doing the oral sex has bleeding gums, mouth ulcers or open sores in the mouth or throat. Oral sex on a woman with HIV is less risky than oral sex with a man who has HIV. Barriers such as 'dental dams' (latex squares) can be used during oral sex with a woman.

- Oral sex on a man. This is safer if the man wears a condom. It is risky without condoms if the person doing the oral sex has bleeding gums, mouth ulcers or any open sores.

Safer sex and HIV testing

Mr S was aged 29 years and unmarried. After seeing an advertisement in theatres he was worried about AIDS. During the course of the risk assessment, he informed the counsellor that he had sex with Commercial Sex Workers three times without using condoms to reassure himself about his virility, masculinity and sexuality. The counsellor explained about STI and HIV, the mode of transmission, symptoms, available testing methods, the window period and treatment. He had an examination and did not have any symptoms of STI. After pre-test counselling, he decided to have an HIV test because he had not been with a CSW for nearly four months. He was found to be HIV negative.

During the post test counselling, he was given detailed information on safer sex and explored the advantages and disadvantages of each option. He now knows all the safer sex practices. He is happy that he can engage in safer sex and plans to get married soon.

4.2 Introducing the issue of STI/HIV

The points below give some ideas on how to introduce the topic of STI and HIV into your counselling session. Find your own ways to do this. If clients come to you expressing concerns about HIV or STI, affirm their sense of responsibility and decision to take action. Assure them of confidentiality.

- Explain that your clinic aims to provide a complete service for all its clients. Each client will have their particular needs, so we want to give all clients an opportunity to discuss and get help on any aspect of their sexual lives.
Ask: "Would you like to discuss anything concerning STIs or HIV? If you are busy today, we could arrange another time"
- Many people wish to protect their fertility and have healthy children and one of the ways your clinic can help clients do this is to protect themselves from STI/HIV.
- You may find it easier to begin to talk about the risk of STI/HIV when you are helping your clients to choose a contraceptive method. You could then begin a more in depth exploration of their risk and options for reducing it.
- If the client says nothing about HIV in a family planning counselling session, you might say something like: *"There is a lot of concern these days about HIV and AIDS. We like to give all our clients an opportunity to discuss this issue with the counsellor so that they can think about their own lives and take any necessary action to stay safe. Would you like to do this?"*
- If clients do not wish to talk about STI or HIV, only do what you can to ensure that they are aware of the potential risk of STI and HIV and what they can do to reduce those risks.
- Encourage all your clients to tell you about any genital signs or symptoms that concern them. Women are often too embarrassed to talk about genital problems.
Ask: "Do you have any problems in your private parts that you would like to talk to me about? For example, vaginal discharge?"
"Do you have any worries about illnesses passed through sex that you would like to talk to me about?"
- Offer visual screening for signs and symptoms of STI.
- Explain that some women do not show any signs or symptoms of STI but the germs can still be damaging their organs. Offer your client screening tests if you provide this or they are available locally. Explain the test procedure. See section 4.5

4.3 Helping clients to assess their risk of STI and HIV infection

- Begin with sharing knowledge about how STI/HIV is transmitted and then exploring the possibility of transmission in clients' lives. Help them to reflect on their (and their partners) past and present sexual and drug-using behaviour and whether this may have put them at risk of STI and HIV infection. They also need to think about their medical history and whether they might be at risk from blood transfusions.
- Help clients to talk about all their sexual activities and partners. Do not make any assumptions about clients' sexual activity nor the activity of their sexual partners. The client may have or have had partners of the same sex or the opposite sex now or in the past. A married person may have relationships outside marriage or their partner may have such relationships. An adolescent may be abused at home.
- As you explore this, provide information on the level of risk of different sexual activities. Probe about other possible activities that the client may not have thought significant or may not like to mention.
- Discuss each of their concerns in detail, learning about their understanding of HIV and adding information as needed.
- When you have covered all their concerns, ask about any risk factors that they have not mentioned.
- When you have talked over all the issues, summarise the main points and ask how the client feels about their likely risk. Share your own assessment of their likely risk. Move on to make a risk reduction plan or talk about the HIV test if appropriate.

You may find it useful to adapt the questionnaire overleaf.

Risk Assessment Questionnaire

- Can you tell me more about your concerns? What is it that worries you? What do you think might have put you at risk of HIV? (Or use question above)
- Are you in a sexual relationship at the moment? Would you like to tell me about it?
- How long have you been with this person?
- What do you like to do together sexually?
- Do you feel that this relationship puts you at risk of unwanted pregnancy?
- Do you use any method to stop pregnancy?
- Do you feel that this relationship puts you at risk of STI or HIV infection? If yes, why do you think that?
- Do you use any method to prevent infection?
- Does this person have any sexual partners apart from you? (Girlfriends, boyfriends etc)
- Do you have any other sexual relationships apart from this one?
- Before this sexual relationship, were you with someone else? Would you like to tell me something about that relationship? (Ask about length of time, other partners, use of condoms, person's sexual behaviour)
- Have you ever had a reproductive tract or sexually transmitted infection? (Explain signs and symptoms) Do you have any of these signs and symptoms now?
- If yes, how long ago was this? What treatment did you receive? Did you recover fully? Why do you think you got this infection? Did you do anything to avoid getting such an infection again? What did you do?
- How is your health generally? Have you been feeling strong and energetic lately? What illnesses have you had recently?
- What work do you do? Does this ever involve having sex with people at work, bosses or clients?
- Do you ever exchange sex for things that you need such as money, food, books, exam results, work, transport or material goods? Could you tell me more about that? Might this put you at risk of HIV? Do you do anything to reduce this risk?
- Do you travel with your work?
- Do you ever drink alcohol? When, where, how much? What effect does it have on you? Do you ever get together with someone sexually after you are drunk? What effect does this have on your sexual activity?
- Do you use any other substances to make you feel good? For example, cannabis? How often and where? How does this make you feel? How does it affect your sex life?
- Have you ever had a blood transfusion? Where and when was that? Who donated the blood? Do you know whether the blood was tested for HIV?
- When did you last have an injection? Who gave it and where? Was it a disposable syringe and needle or did you see it being boiled or disinfected?
- Have you ever injected drugs to make you feel good? Do you think that this put you at risk of HIV? Why or why not? Discuss where, when, did you share needles, did you sterilise the needle before you used it?
- Have you received treatment from a traditional practitioner recently that involved cutting or breaking the skin? Might it have put you at risk of HIV? Why or why not? Discuss what instrument was used? Was it new or boiled before use?

4.4

Helping clients to make a plan of action to reduce the risk of STI/HIV infection for themselves and partners

KEY FACTS

- **Options for safer sex include.**
 - 1 abstinence from penetrative sex.
 - 2 uninfected partners being faithful to each other.
 - 3 using condoms every time you have sexual intercourse.
- Different options may suit people at different times of their lives.

Choosing the best option

- Help your clients to explore the three options above. Explain that they can make a choice that suits them now and change it as their circumstances or preferences change.

- Clients, whether living with HIV or not may have to rethink their sexual relationships. Support clients at risk in finding other ways than intercourse to express their sexual feelings if condoms are not available or they don't feel able to use them.
- Recap on all the sexual activities discussed earlier with your client and their level of risk. Give the client information on other activities that they might enjoy as appropriate and on how to make preferred activities safer. See section 4.1.
- Explore with the client the good and bad points of each choice in terms of level of HIV (and pregnancy) prevention, enhancing relationships, intimacy and pleasure, partner's preference, other consequences, practicality and feelings. Help clients to think about potential results of each choice.
- Help clients to come to their own decision. They may need more time to think about the options and discuss them with others. Women may put themselves at risk of abuse if they speak to their partners about condoms or fidelity without careful thought and preparation.
- When clients have expressed a preference, help them to explore in more detail to check on whether it is a good choice and to think about how to put their intentions into practice.
- Help the client to gain any skills needed to put their plan into action, for example, how to use condoms and talk to their partner.

Ask:

- *What previous positive experiences do you have of practicing the chosen low risk behaviour? What helped you to manage this?*
- *What were the difficulties and barriers to practicing safer sex? What, if anything, helped you to overcome the barriers?*
- *How will you talk to your partner(s) about engaging in these safer sex activities? How do you think they will respond? What can you do to make it easier for them to enjoy the safer sex activities? Use role-play to help clients to practice talking with partners about safer sex.*
- *What steps do you need to take to begin practicing the new behaviour?*
- *What positive and negative things might happen at each step?*
- *What can you do to make it easier to adopt the safer behaviour?*
- *What support can I give you and what support will you need from others?*

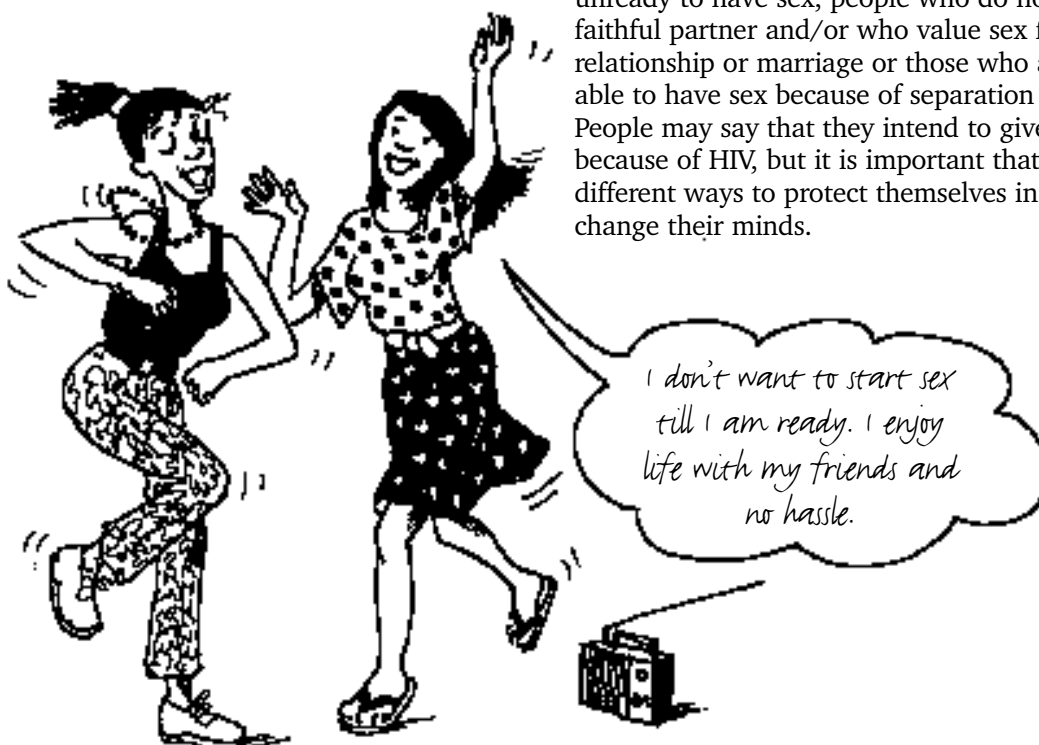
In the following sections we discuss each option in more depth.

Helping clients to abstain from sex

Abstinence means a person does not engage in vaginal or anal sexual intercourse. Some people believe that abstinence means no sexual activity of any kind, others that people who are abstaining may still engage in non-penetrative sexual activities. Some people think that it is easier to abstain if they do not engage in any sexual activity at all because they may find it difficult to stop without intercourse.

Abstinence may be a good choice for young people who are in unequal power relationships or feel

unready to have sex, people who do not have a faithful partner and/or who value sex for a special relationship or marriage or those who are not able to have sex because of separation or illness. People may say that they intend to give up sex because of HIV, but it is important that they plan different ways to protect themselves in case they change their minds.



You can help people to keep to a decision on abstinence by using the steps in 4.4.1, identifying situations and factors that might make abstinence difficult and helping your client to practice responding assertively to people proposing sex.

Helping clients to enjoy sexual pleasure without intercourse

People who are abstaining may still express their sexual feelings by the non-penetrative sexual activities listed in section 4.1 and others that they have discovered themselves.

Women and men's sexuality differs and some women may actually get more pleasure from sexual activities other than intercourse. The dominance of men has tended to focus sex on intercourse and many people feel that this is the 'real' sex, the sex that results in conception. Others think that non-penetrative sexual activities are enjoyable and valid and do not feel that intercourse is essential for expressing their sexuality.

In some cultures young people are taught how to express themselves sexually without intercourse. In others, young people learn by themselves or from each other how to please each other without intercourse. This sexual play can be safe and enjoyable for both people.

The main risk is that the couple become so excited that they are not able to stop and go on to have unprotected intercourse. Unless there is trust and commitment, the man might force the woman to have intercourse with the excuse that he is unable to stop.

Some people may enjoy sex without intercourse for a long period of time. For others, one or both partners may become very frustrated and tense and this can cause conflicts in the whole relationship.

Help your clients to explore all potential safe and safer sexual activities and to find strategies for introducing them in their relationships if necessary and reducing the risk of unprotected intercourse.

You can help people to move from sex without intercourse to sex with condoms or to move towards VCT and a stable relationship, if the choice to enjoy sexual pleasure without intercourse is not working well for your client.

Helping clients to stay with uninfected partners who only stay with them.

KEY FACTS

- This choice is important in reducing HIV infection, particularly where HIV transmission rates are low or condoms are not available, affordable or acceptable.
- Clients and their partners can only know that they are both uninfected if they have an HIV test and practice safer sex from then on. Or if they became sexual partners as virgins and then had no other sexual partners, blood transfusions or unsterilised injections since then.
- HIV can stay in the body for ten or more years without symptoms so people who had unprotected sex before marriage may be HIV positive even though they have not had any other partners after marriage. In many cultures, men and sometimes women have several sexual partners before they marry.
- HIV testing and discussions about possible HIV infection in stable relationships are difficult because they can imply a lack of trust and fidelity. Many couples stop using condoms after they have been together for six months or so because they now 'trust' each other. They may wish to conceive a child. However, the decision to practice safe sex has nothing to do with trust because without an HIV test, no-one who has been sexually active can know whether they are infected or not.
- Married people may have (or have had) secret sexual relations outside marriage and never tell their partner. Partners may be unaware of risk. Married people may use condoms with outside partners to protect themselves and their family from infection without telling their spouses. This strategy does not allow the spouse to make an informed decision on the level of risk they are willing to live with because condoms do not provide 100% protection.
- Counsellors often find it difficult to counsel married women on HIV because it requires them to acknowledge that their spouses might have outside partners and then talk to them about it. If the woman decides not to talk to her partner, she may become anxious and cease to enjoy sexual relations. If she does talk to him, it may result in rejection, abuse or violence.

How can counsellors help?

- Counselling which puts the responsibility for change to safer sex on an individual, particularly if this is a woman, may increase stress and the risk of negative consequences.
- Counselling is likely to be more effective if it is part of a broader health promotion strategy, which includes health education and opportunities for dialogue between men and women, young and old in the community to create enabling and supportive environments.
- Couple counselling to find ways to enhance sexual pleasure and intimacy or counselling partners separately may be helpful. Small group counselling in single sex or couples groups can help people to explore the issues, agree on change and support each other.
- Clients may decide that they are prepared to live with a level of uncertainty about their risk in order to maintain a good relationship with their partner. If the HIV prevalence is low and clients feel that their partner practices safer sex, the level of risk may actually be low.
- Even in high prevalence areas where condom use is low and extra-marital sexual relations common, clients may still decide that they prefer to live with the risk of HIV than risk upsetting their relationship. This is their decision and your role is to ensure that they have explored all the possibilities and have access to all the facts.
- Help your clients to explore and practice ways to talk with stable partners about HIV, perhaps through role-play.
- Be aware of new safer sex techniques that women can use independently of their partners. For example, the female condom and microbicides.
- Explore with clients and groups the reasons why people might have more than one sexual partner and what would help people to stay with one partner. For example, making contraceptives available can enable couples to enjoy sex without fear of pregnancy at any time and this can reduce interest in having outside partners.

Helping Clients to Use Male/ Female Condoms

You will need male and female condoms and it will help to have a penile model and pelvic model and leaflets explaining condom use for clients to take away.

The Male Condom

- A man can use a thin rubber sock called a condom. The man or woman unrolls the condom onto his erect penis before sex starts.
- The condom prevents the man's sperm from getting inside the woman, so they cannot join with the egg. This prevents pregnancy.
- Condoms also protect against STI/HIV infection because the germs that cause these infections cannot get through the condom from the man to the woman, the woman to the man, or the man to the man.
- After ejaculation, before the penis gets soft, the man withdraws and carefully removes the condom. He takes care not to spill any sperm on the woman's genitals.
- Condoms are very effective if they are used correctly and consistently at every act of intercourse. The condom should be put on before any genital contact. They are even more effective against pregnancy if a spermicide like Neo-sampon is used with them. If people do not use them all the time, they are much less effective than other methods against



pregnancy. However, they are the only method that currently protects against STI including HIV. It is better to use condoms sometimes than not at all.

- Condoms have no effects on the body except in about 8% of people who are allergic to rubber. They allow the man to take some responsibility for family planning. It is important to store condoms in a cool, dry place out of sunlight.
- Condoms are a good choice for people who want to have dual protection from pregnancy and STI/HIV. They are also a good choice for clients who have sex infrequently or do not want drugs or devices affecting their reproductive system.
- Condoms are a first choice method for breast-feeding mothers because they have no effect on breast milk production and protect mother and baby from STI and HIV infection through breast milk. They are good in cultures where people believe that semen will poison breast-milk because the condom prevents the semen from reaching the breast-milk.
- Condoms are the best choice for young people because they protect against STI/HIV. This protects their future fertility and life and prevents pregnancy. However, young people need to be motivated and helped to use them regularly and correctly.
- Many couples find they enjoy sex more with condoms because they do not have to worry about pregnancy and STI/HIV. Also, condoms can help prevent premature ejaculation.
- Female condoms are now available and are described in detail on page 32.

Steps in counselling

- Ask whether the client has any experience of using condoms. If they do, ask them about their experiences, any problems they faced, how condoms affected their sexual life, any worries they have about them and what they think about using them again.
- Provide information as needed. Demonstrate how to put on a condom and ask the client to show you how to do it using a model penis.
- If the client has no experience of using condoms, ask what they have heard about them, how they feel about them and what barriers they might have to using them.
- When you have understood the client's concerns about condoms, explore how they might be solved. Always be honest about the problems that can arise with condoms, but also be positive and say that many people use them happily.

Ways to help clients with worries about condoms

WORRIES ABOUT CONDOMS	HELPING CLIENTS TO COPE
The condom might go out of the vagina and around the body.	Use a picture to explain that the condom cannot get out of the vagina.
Condoms make it impossible to have a baby.	Explain that condoms can protect the mother and father from HIV or STI until the couple is ready to conceive; they also protect fertility. When the couple are ready to conceive, they could consider taking an HIV test and/or stop using the condoms until they conceive.
Reduction in sexual pleasure.	Put spermicides or saliva inside and outside the condom. Spend time increasing sexual pleasure through caressing, kissing and romancing. Condoms prevent premature ejaculation and can increase pleasure.
Pain during sex.	Condoms should not cause pain during intercourse. Dryness can cause pain. Try using more caressing, spermicide or saliva to make the vagina wetter. If this does not help, the couple should go for a check up in case they have an infection or are allergic to rubber.

WORRIES ABOUT CONDOMS	HELPING CLIENTS TO COPE
Condoms sometimes break or slip off.	If condoms are used properly they rarely break and if they do the chances of infection or pregnancy are low if the right action is taken. We describe how to reduce the risks below. (Ways to reduce the risk of breakage; How to minimise the risk if a condom does break)
Condoms have holes which let through HIV or they contain HIV.	Condoms do not have holes which can let through HIV if they are not expired and properly used. Overall, condoms are 95% effective against HIV, which is much safer than not using them at all.
Some people think that condoms are only for single people or those who have many partners or sex workers.	The image of condoms is now changing because many people want to keep their family safe from HIV as well as preventing pregnancy. So it is seen as a moral, caring practice for married people as well as those having sex outside marriage and couples living together.
Condoms are costly or not locally available.	Try to find ways to make free condoms available at all times to those who need them. Help people to engage in non-penetrative activities when they cannot obtain condoms.
It is embarrassing to buy condoms.	Look for ways to make condoms available privately eg. vending machines.
Condoms don't always fit because men have differently-sized penises.	Condoms do vary in size and tightness and if available, you can suggest that men select the most comfortable one. In resource poor settings, there may be only one type of condom. They may be too large for adolescents or too tight on men with large penises. The condom can stretch to a large size but sometimes the rim is tight enough to cause pain.
How can you help?	Try the female condom. It is less tight. Could your programme order a batch of looser fitting condoms for those who need them? Smaller condoms for adolescents are available and you could order them.

Ways to reduce the risk of breakage:

- Avoid dry sex and do not put powders into the vagina. If the woman is dry, use spermicide foam or water-based jelly.
- Do not use Vaseline or any oil on the condom, it will spoil the rubber.
- Do not use condoms that are more than 5 years older than the date of manufacture on the packet. If the condoms have been kept in a warm place they will last for less time than this.

How to minimise the risk if a condom does break:

- Use a spermicide as a double layer of protection;
- Stop sex at once if either of you feel the condom break and pull out. If the man has not

ejaculated the risks are low. Put spermicide into the vagina.

- Go to the nearest clinic for emergency contraception (EC may also be available over the counter in some countries) as soon as possible, but at least within 72 hours of the breakage.



The Female Condom

The female condom is a sock made of plastic with a ring at each end. It works in the same way as the male condom by stopping sperm getting into the vagina during sex.

The female condom protects against pregnancy, STI and HIV in the same way as the male condom. It is about 98% reliable if used correctly every time. Female condoms are popular in some places. Women may find it easier to negotiate or insist on the use of the female condom than the male condom. Men and women may find them more comfortable than male condoms because they are looser. They may be seen as 'respectable' for married couples, perhaps because they are new.

To insert the condom:

- Wash your hands. Rub the condom to spread the lubricant.
- Hold the ring of the closed end. Squeeze the ring.
- Put the condom into the vagina as far as it will go. The ring should be at the end of the vagina.
- Push the condom up the vagina, leaving the other ring outside the body. Make sure that the condom is not twisted. Make sure that the outer ring is lying on the vulva,
- During sex, ensure the penis is inside the condom and not between the wall of the vagina and the condom.
- To remove, squeeze and twist the outer ring, pull out, wrap carefully and put in latrine or a

place where children cannot find it.

- For extra moisture and comfort use saliva, spermicide or an oil-based lubricant inside the condom. (This will not break the plastic as it does the rubber on a male condom.)
Add extra lubricant if:
The outer ring gets pushed inside; the penis sticks or if you hear noise during sex.
- Do not re-use female condoms. The safety and feasibility of re-use is currently being researched.

Disposal of condoms

Explain the dangers of throwing condoms anywhere. Ask how the client will be able to dispose of the condoms. What might make it difficult? Try to find a solution to any barriers to disposal. Maybe the client could dig a latrine or wrap it in paper or leaves until he/she reaches one.

Helping clients whose partners refuse to use condoms

A man or a woman might refuse to use condoms for a number of reasons.

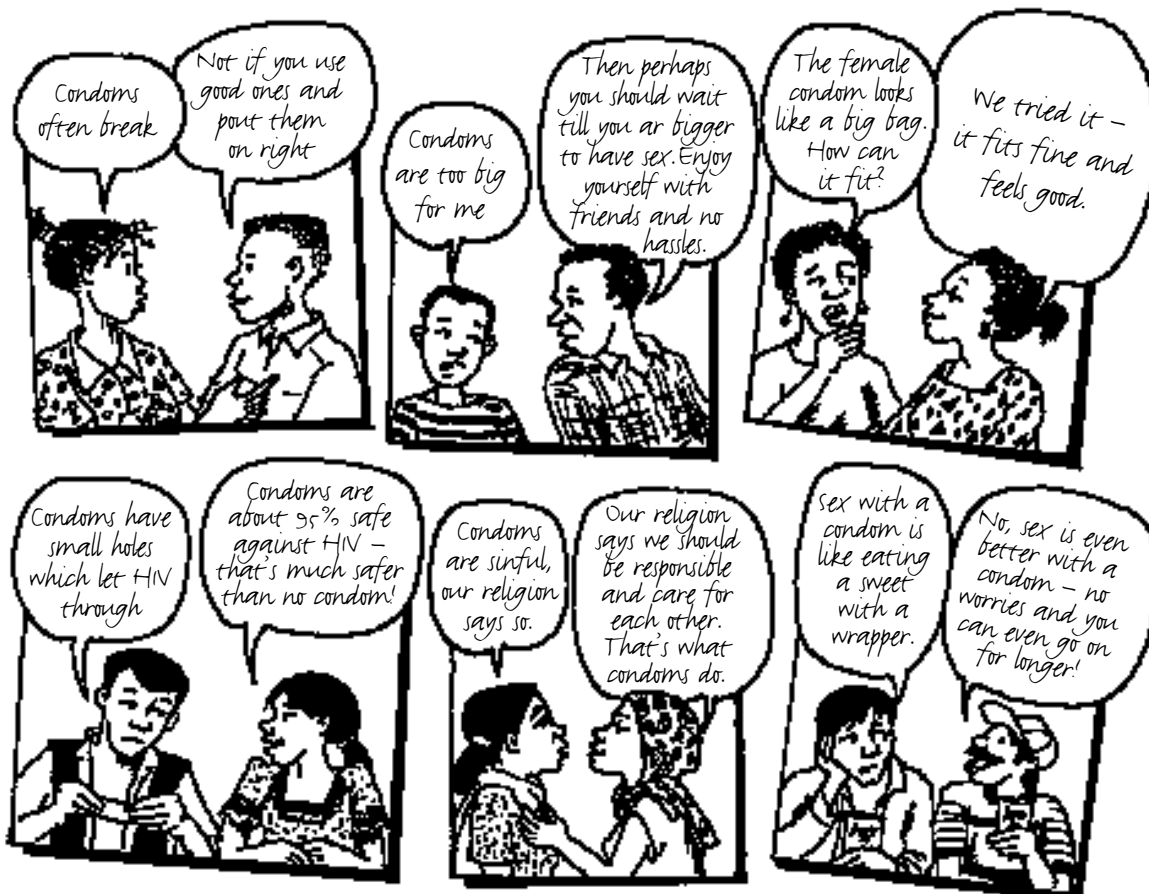
- Explore with your client why they think their partner does not want to use condoms. Empathise and think about what might help them to try condoms. If it is helpful, role-play the situation with you as the client and the client playing his or her partner. This can help them to understand their partner better.
- For many people, skin to skin contact and the intimacy between people during sex is very highly valued both physically and spiritually. It is not easy for people to change these deeply held values.
- Some men have difficulty getting or maintaining an erection using a condom. Couples may get used to the condom in time and forget that they are using it. Help your client to focus on pleasuring the body. If it is helpful, try to counsel both partners, either together or separately.

Negotiation techniques

Negotiation is a discussion with another person, in order to reach a mutual agreement on a given issue. Acquiring skills in negotiating for safer sex is therefore very important.

Ways to help negotiation to go well

- Ensure that the environment and surroundings are comfortable, private and with no



interruptions or distractions

- Give both of you enough time, whenever appropriate, to focus on the discussion. Avoid awkward situations, for example after a quarrel.
- Tell your partner that you want to discuss something important in advance and agree a time and place to allow you both time to prepare for the discussion.
- Be confident and say clearly what you know, feel and think without hurting your partner. Be sure of your facts and committed to change. Say clearly what you would like and do not be afraid of losing or offending your partner. Be assertive rather than attacking or pleading. Don't blame him or her.
- Encourage your partner to make the first contribution to the discussion and give him or her time to speak and think. This will help you to see how he or she is feeling about the issue and it will help you to relax.
- Be ready to listen to your partner with an open mind. Don't assume you know how he or she thinks and feels.
- Try to have a positive attitude. Stay calm and try to reach an agreement on each point as you go along; this helps to build a positive atmosphere.
- Try to talk your partner into agreement in a loving way rather than threatening or begging.
- You might need to ask for help and support from a very close relative or a friend and ask him or her to talk to your partner on the issue in your absence.

The most important point of all is that, in order to succeed in negotiating for safer sex, the client must know the facts about HIV and AIDS and about safer sex options.

**Taken from the HIV/AIDS Prevention Trainers Guide Training Manual.
Aidscom, Uganda.*

Explore alternatives to sexual intercourse when condoms are not available. Section 4.1

4.5

Counselling a client with an STI diagnosis

Steps in counselling

- Affirm your client and assure her or him of confidentiality.
- Encourage your client to tell you about any signs and symptoms, recent sexual interactions, fears and what they have already done to try to solve the problem.
- Explain that the examination or test showed that they have an infection in their genitals passed through sexual intercourse. Explain and answer the client's questions about it.
- Explain that STIs can have serious consequences if they are not treated as quickly as possible. Explain the potential consequences of your client's particular STIs if they are not treated.
- Explain that most STIs are curable if they are treated early with a complete course of the correct drugs. Explain about the prognosis for your clients STI. Stress the importance of taking the full course of correct drugs. Too little of the correct drug may make the infection difficult to cure next time. Wrong drugs or local treatments may not kill all the pathogens or cure the infection.
- If necessary, refer your client to the best local facility for STI treatment and discuss any barriers she/he has to seeking treatment there. If she/he has concerns about issues such as travel, costs, attitudes of providers and confidentiality, look for ways to work with the service providers to improve the quality or get an exemption.
- Explain what will happen at the health unit, when it opens and what the nurse will need to know and do.

Informing partners about the infection

- Explain that clients need to tell all their sexual partners about the infection so that they get treatment. If women have no symptoms and are not told and treated, they may become very ill or infertile and they are at higher risk of HIV. Also, partners can re-infect each other every time they have sex if they are not both treated.
- Generally it is difficult for women to tell men about STI infection because of gender inequality and men often do not wish to tell their partners. This is a serious problem, which you can help to solve in collaboration with community programmes.
- Explore the best way for clients to tell their partners about the infection. Think about when, where, who and how. If it helps, role-play the best approach and timing. Ask how the partner

might react to the news and what the client could do to minimise risk of rejection, conflict or abuse.

See negotiation techniques, section 4.4

- If clients are anxious about telling their partners or are not able to do so, explore alternatives with them. Take great care not to push them into a potentially dangerous situation.

Ask:

“Is there a relative, friend or community member who could help you to do this and mediate in any quarrels?”

“Would it be helpful to counsel your partner alone or together with you?”

“Is there a way that you could avoid sex until you are cured and you have more time to sort out a strategy?”

- Partners may refuse to come for an STI test and/or treatment, especially if they do not have symptoms. They may wish to go to a different facility and/or take treatment without counselling or a test.
- Clients may refuse to tell their partners because they blame them or they want to keep their outside relationships secret. Some people lie to their stable partners about the nature of an STI. This may prevent quarrels but everyone has a right to information about their risk of STI/HIV.
- Understanding of the risks of infertility and damage to babies can motivate people to seek STI treatment promptly and to inform their partners. Understanding the increased risk of HIV and its impact on both clients and families can motivate a change of behaviour.
- Group counselling for men can help to change attitudes.
- Both partners should abstain from sex until they are completely cured. If they are unable to do this, they should use condoms each time they have sex.
- Explain that STIs increase the risk of HIV. Stress the importance of prevention of STI and ask if clients wish to consider taking an HIV test.

Restoring harmony in the relationship

If your client is in an ongoing relationship, STIs frequently result in conflicts because they imply that one or both parties have had a relationship outside. Women are often blamed, punished and rejected more than men, although their stable partner often infects them.

- Ask the client how she or he is feeling. Give her or him time to express their feelings about the situation.

“I see that you are feeling very angry that your partner has given you this infection, is that right? Would you like to tell me more about what you are feeling?”
- If you are counselling a couple, give them a chance to say how they feel to each other while the other person really listens.
- Give positive examples of couples who have been in this situation and come through it and are still together.
- Help the couple to really listen and talk to each other about their thoughts and feelings to increase their understanding. Help them to talk about what they like sexually and what they can both do to avoid this problem in future. In this way, you have an opportunity to help the couple to talk more openly about what is going on in their sexual lives. Although this can be painful, it may finally help the relationship.
- If you are counselling one person, use role-play to practice communication.

Prevention of future infection

Having an STI may motivate clients to practice safer sex from that time onwards, if they understand that STIs can be serious and fatal, and increase the risk of HIV.

See ‘Helping clients to make a plan for risk reduction’, section 4.4.

Follow up

Clients may need more support in talking to their partners, accessing and taking the correct treatment, and changing their own behaviour or that of their partners so they are not infected again.

- Arrange when you will next see the client to see whether they are cured and how their relationship is going.
- Find out whether they have been to the health unit, what medicine they are taking and whether the signs and symptoms have gone.

Aims

- To help your client to freely make an informed choice on whether or not to take the HIV antibody test on the basis of full and accurate information on the potential benefits and costs in their lives.
- To explore clients' knowledge of HIV/AIDS and provide them with correct information.
- To assess clients potential exposure to HIV infection through past and present behaviour and events.
- To encourage clients to take appropriate action to reduce their risk of contracting or transmitting HIV to others.
- To explain the process of testing.
- To help clients prepare themselves for the result, whether negative or positive.
- To help clients prepare themselves for the social, legal and ethical issues arising after the test.

This section covers issues around informed consent and the HIV antibody test. See Section 4.3 'Helping your clients to assess their risk of HIV infection' and 4.4 'Helping clients to make a risk reduction plan' for detailed information on these topics.

KEY FACTS

- Most blood and saliva tests for HIV detect antibodies to HIV, they do not detect the virus itself.
- When HIV enters the body, the person starts to make antibodies to fight the infection. Most people take about three months to six months to make antibodies to HIV after infection. This is called the window period.
- People should wait at least three months after being exposed to risk before taking the test. Otherwise a negative result may just mean that they have not yet made antibodies. To be more certain, a person with a negative result could have another test after six months without being exposed to risk.
- The test only tells people whether they had antibodies on the day that they took the test. If they were exposed to risk during the three months before taking the test, or after taking the test, or if they have not yet made antibodies, a negative test result tells them nothing.
- Usually the ELISA test is done first and if the result is positive, it should be repeated and if possible confirmed by the Western Blot test.
- Rarely the test result is not clear because the person is in the pre-seroconversion phase. The client should have a repeat test.
- A positive HIV test has serious consequences for the person tested and others. It is very important that people think through the possible advantages and disadvantages carefully before they make a decision.
- An HIV antibody test should always be voluntary. It is against human rights to pressure or force someone to have a test without informed consent.

5.1 Helping clients to decide whether to have an HIV antibody test or not

This section addresses specific needs in counselling to make a decision about whether to have an HIV antibody test or not.

Risk assessment and making a risk reduction plan

Details of counselling on risk assessment and risk reduction are covered in 4.3 and 4.4.

- Affirm clients' concerns about HIV infection and assure them of confidentiality.
- Explain that you will work together to help them to make the best decision about the HIV antibody test. The test is entirely voluntary and there will be no pressure to take the test. Even if the client does not take the test, talking things over will be helpful.
- Explore the reasons why the client is seeking counselling for HIV and AIDS.
- Share knowledge about HIV/AIDS and ways of transmission and prevention.
- Reflect together on past and present sexual behaviour and exposure to blood or sharp instruments and needles and possible risks.



See risk assessment questionnaire, section 4.3.

At the end of the risk assessment, summarise the main points and ask the client how they feel about their possible risk of HIV infection in the past and now. Share your own assessment of their likely risk. This helps to prepare them for the result if they decide to have a test and is part of the process of informed choice. However, it may not be possible to assess risk reliably because clients may not know about their partners' behaviour or they may edit what they tell you to maintain dignity and identify.

If appropriate, work together to make a risk reduction plan. See section 4.4.

Exploring the advantages and disadvantages of having a test

Find out what clients know about the HIV antibody test.

Explain how the HIV antibody test works, the window period and the meaning of a positive, negative and uncertain result.

Help clients to explore the advantages and disadvantages of taking the test in their own lives.

The table below gives some ideas on this. Provide information as appropriate to build on the client's knowledge.

ADVANTAGES	DISADVANTAGES
<p>The test can:</p> <ul style="list-style-type: none"> ■ Motivate people to reduce their risk of HIV infection and the risk of infecting others. ■ Enable couples to enjoy any kind of sexual activity without condoms if both partners are negative and stay only with each other. ■ Enable couples to make an informed decision on whether to have children or not. ■ Help parents to take action to reduce the risk of mother to child transmission. ■ Help health workers to provide the best treatment to patients with HIV. ■ Help people to join a support group. 	<ul style="list-style-type: none"> ■ Rarely people may get a false positive or negative result, then they may suffer distress and severe consequences unnecessarily. Or they may worsen their own health or infect others unknowingly. ■ People may react badly to a positive result. They may drink too much or have unsafe sex. They may become depressed and suicidal. ■ People with a positive result may lose their marriage, children, home and job if others get to hear about it. Women are very vulnerable, they may be isolated, beaten and stigmatised, with severe long-term effects on their well-being and family lives. ■ People with a negative result may be so relieved that they have more risky sex, thinking

ADVANTAGES

- Stop people worrying and help them to take positive action whatever the result.
- Help to normalise HIV and reduce stigma if more people take the HIV test and are open about their status.

DISADVANTAGES

- that they are immune.
- If a person with a positive result does not have the power to do anything about it, they may feel more anxious and unhappy after the test.

Taking an HIV test

Never persuade or pressure clients to have an HIV antibody test. For any individual, the disadvantages of doing this may outweigh the advantages, particularly if testing facilities are poor or they are not in a powerful position in the family.

Some clients may decide to have a test, but then think more about the advantages and disadvantages when they go home and discuss it with others. They may then decide not to come for the results. These clients are not 'drop-outs' – this is part of the informed choice process. We expect a lot when we ask clients to decide after one counselling session. If the client decides to have the test, continue with the next steps. If the client decides not to have the test, help them to summarise their risk reduction plan and support them in their action. Encourage them to visit you again at any time for further counselling.

5.2

Counselling clients who have decided to have an HIV antibody test

Obtaining consent for HIV testing

Explain that the test is voluntary; no-one is forced to have it. Ensure that your clients understand and have considered the implications of having the test. If they decide to have the test, ask them to state specifically that they wish to have the test and do not feel under any pressure from anyone to do so. Set up procedures to ensure that informed consent is given. (This is not easy when there is a large educational and power gap between provider and client.)

Cost of test: Tell the client the cost of having the test if they have to pay for it. Ask if this presents any problems for them. Try to set up an exemption scheme for those who cannot afford the test. Explain the **testing options** available in your area.

Explain how the test will be done and when the results will be ready. Remind them about the window period, the need to avoid exposure to HIV before the test and the meaning of the results.

Helping clients to prepare for a positive or negative result

This can help clients to respond better to the results and take positive actions as early as possible. It helps you to support them in a more informed way.

Ask:

- *How do you think you might feel if your result is positive? How do you think you might react? What has helped you to cope with bad news or difficult times before?*
- Explore past anxiety, depression and tendency to self harm or alcohol and drug abuse.
- Explain that couples may have different HIV test results. One partner may be positive and the other negative. This is called a discordant couple. This can happen because one person was exposed to HIV outside this relationship and has not infected the other person because of condom use, immunity or low exposure of the partner.

Ask:

- *“How do you think you would feel if you were positive and your partner negative and vice versa? What do you think you would do? How might your partner respond?”*

Putting social support in place

It is important that clients think about how they will cope when they get the test results and who will support them. It is very important that they do not tell anyone without thinking about it carefully because of stigma.

Ask:

- *How do you cope with problems in your life – who helps you, what makes you feel strong and able to cope, do you have activities like religion which give you courage?*
- *Could you tell me about your family situation?*

- Do you belong to any networks of friends, community support groups, clubs, religious or other groups that support you?
- Who do you think would help you if the test result was positive? Or negative?
- Did you tell anyone that you were thinking of having an HIV antibody test? Why that person?
- Who would you tell about the test results

5.3 HIV antibody testing that is not voluntary

Pressure may be put on people to have an HIV antibody test by partners, family, religious body, workplace or visa departments. Some interventions are only accessible to people who have agreed to have an HIV antibody test.

Putting pressure on someone in any way to have an HIV antibody test is a violation of human rights and unethical. Counsellors should explain this and explore alternatives if clients wish.

Pre-marital HIV counselling

It is common in some places for couples to have an HIV test before marriage. Sometimes one or both of them decide to do this themselves, sometimes the church or their families demand it. Some religious bodies refuse to marry people if one or both have HIV infection. This is a violation of human rights. If couples or individuals are obliged to have a test before marriage, the testing is no longer voluntary and there is no informed consent.

Pre-marital counselling and testing can help couples to:

- Make an informed decision about whether to get married.
- Talk about their sexual life together.
- Make informed decisions about safer sex and the need for condom use.
- Motivate couples to practice safer sex from now on.
- Make informed decisions about having children.

A positive test result can lead to rejection and distress, particularly if one person tests positive. However, some couples stay together, support each other and grow in their love.

If the test is not voluntary, explain that testing should be voluntary and they have a right to give informed consent. If they wish, explore their possible risk of infection, the pros and cons of the test and what might happen if one or other or both had a positive or negative result.

Talk through options with them, for example, to marry in a different way that does not demand a test or to discuss it further with family and partners. Help them to reduce their risk of HIV infection in their marriage. If they decide to take the test, help them to prepare for it.



Everyone needs to practice safer sex, whatever the test result

Aims:

- To help clients to understand the meaning of and come to terms with their result.
- To help clients to express their feelings about the result.
- To help clients to make a plan of action for the immediate and short term future.
- To help clients to decide what to do about disclosure to sexual partners and others.
- To help clients to reduce their own risk of HIV infection and infecting others.
- To help clients access the medical, psychological and practical support they need.

6.1 The meaning of the test results**KEY FACTS**

- An HIV positive result means that the test has detected antibodies to HIV in the blood. It does not mean that the person has AIDS or that they will soon die. If people with a positive result are healthy, they have HIV infection and may live for many years. If people with a positive result have illnesses related to HIV infection, they may have AIDS and can be helped with treatment and care.
- Rarely some HIV tests give a false positive result. The test should be repeated and confirmed if possible with Western Blot before disclosing the positive result to clients.
- An HIV negative result means that the test did not detect any antibodies to HIV in the blood. If the person has not been exposed to HIV within the past 3-6 months, they are most likely not infected with HIV. If they have been exposed to HIV in the past 3-6 months, they may not yet have made antibodies. They may still be infected. In this case, the person needs to have another test in 3 months time to know their HIV status.
- An uncertain result means that the test did not clearly show whether antibodies were present or not. A person may be in a sero-conversion phase and will require another test.
- It is best to have the same counsellor doing pre-test and post-test counselling because they have a stronger partnership and trust, the counsellor is familiar with the client's situation and they can more easily refer back to the plans made by the client in pre-test counselling.
- There is a wide range of possible client reactions to a positive test result, ranging from anger, resignation, bargaining, depression to severe shock and disbelief. Some clients assume they will immediately become ill and die. Clients often show strong emotions, which many of us are not used to coping with, especially in a constrained work situation. The client may speak of suicide, threaten others, be angry with the counsellor or be unable to cope.
- Clients' psychological responses depend on a number of factors including history and personality, social support and coping mechanisms and quality of pre-test counselling.
- If the client has not had good pre-test counselling, you will need to spend more time explaining things to them after the test and helping them to make plans.

6.2 Giving clients their HIV Antibody Test Results**Understanding the result**

- Ask clients how they have been feeling since they had the blood drawn and congratulate them for returning or waiting to hear their test results.
- Ask clients if they have any questions or if they want to talk over anything before you give them their results. Most clients will want to hear their test result as soon as possible.
- When clients are ready, give the test result in a neutral voice and wait for the client to respond before proceeding.

For a positive test result, say:

'your test result was positive; that means that you are infected with HIV,

For a negative test result say:

'your test result was negative; that means we did not detect any antibodies for HIV.'

- Find language which makes the meaning of the test clear to clients. If they are not from a scientific background explain HIV and antibodies in a local way.
- Ask clients what they understand by the test result. Talk it over until they understand.
- Ask if they have any other questions about the result.

Expressing emotions

Ask your clients how they are feeling. Encourage them to express their emotions freely and do not rush them or try to stop them.

Making a plan

When clients are clear about the meaning of the result and have expressed their initial feelings, they may be ready to talk about what to do next and make an immediate plan.

Ask

"What are you planning to do when you leave here today?"

If clients made a plan in pre-test counselling, they need to talk through it again in detail because they may feel very differently now they know their results. The plan might include telling their partner, modifying their risk reduction plan or seeking medical help.

Clients who are HIV positive are likely to need more than one counselling session to come to terms with their results and make and carry out their plan.

6.3**Counselling clients with a positive test result**

Telling clients that they have HIV infection is distressing and difficult for counsellor and client. If the client does not have AIDS, explain the difference between HIV and AIDS again and say that many people remain healthy for a long period of time with HIV infection.

Psychological support

You have a very important role in providing psychological support to clients and helping them to access support systems at home.

- Identify and explore clients' feelings.
- Ask questions like *"would you like to tell me more"*.
- Let clients know that their feelings are natural and that they are likely to change after the initial shock of learning the test result

Explore factors that may influence clients' reactions

- Was the client well prepared for the news? Even if they were, they may still present a very negative reaction to the test result.
- Does the client have any medical problems? These may cause more stress.
- What emotional and social support networks does the client have?
- What is the client's natural personality and psychological condition? News of HIV infection can bring out fears and problems that can complicate the process of acceptance and adjustment.
- What is the level of stigma and discrimination in the community against people living with HIV/AIDS?
- What is the client's cultural and spiritual background? How will this help them to cope with a positive result?

- Talk over again the questions you discussed during the pre-counselling session.
- Explore how clients were able to deal with other difficult situations in the past.
- Identify sources of support available to your client, for example, family, friends, partner, church and clubs. Give the client any additional information about local sources of support, such as groups for People living with HIV or AIDS (PLWHA), church members and counselling organisations.
- Explore clients' ability to cope and ways of coping. These might include song, prayer, long walks, spending time with family and friends or joining a support group.
- If your client expresses any suicidal thoughts or ideas, take them seriously, even if the test is anonymous and confidential. Make sure that they have support before you see them next time.

- Assess the client's medical, preventive, and psychological support needs and discuss access to existing services.

Making a plan

- Ask the client what they are planning to do when they leave the session and, if necessary, remind them of the plan they made in the pre-test session for what they would do if their result was positive. Talk through the plan with them.
- Assess the client's social support and plans for partner notification.
- Help the client to establish a plan for continuing medical, social and psychological support.
- Help clients to identify possible actions that may help resolve or ease their problems.
- Identify with clients tasks that they feel able to accomplish with the counsellor's support.
- Set up a follow up session or refer as appropriate



Making a risk reduction plan

Discuss again the client's risk for transmitting HIV infection to others. Reinforce the message about prevention of HIV transmission and safer sex. Section 4.4.

Many clients who test HIV positive are not concerned about safer sex in the first post-test counselling session. However, they still need to protect their partners from infection and themselves from re-infection.

Discuss clients' responsibility to ensure that their partners are notified and counselled about their exposure to HIV. If they feel unable to do this, discuss how they can reduce the risk of infecting their partners. If the client agrees, help with a plan to contact the partners.

Remind clients of their risk reduction plan.

Think about:

- Is the risk reduction plan adequate given the client's HIV status?
- What are the immediate action(s) that the client must take to minimise the risk of re-infection and the risk of transmitting the infection to others?
- What are the barriers to the necessary actions?
- How can the counsellor help the client to carry out the actions in the risk reduction plan? (for example, assist with partner notification)
- Does the client need additional counselling on safer sex?
- How can you help clients to change their behaviour or stay with behaviours that minimise the risk of HIV transmission?

Practising protected sex is often easier if both partners know their HIV status. If they are both positive, they can protect each other from re-infection with HIV and with other STIs.

This will help to maintain their immunity. If one person is negative and the other positive (a discordant couple) they can protect each other and help the uninfected person to stay negative.

Counselling over time can help individual clients to tell their sexual partners about their status. If a woman has an HIV positive test result and she does not know the sero-status of her partner, she needs to find ways to protect herself and him from infection. If she suspects that he infected her and is therefore positive himself, she still needs to protect the two of them from re-infection, because this can speed up the progression of the infection. The same thing applies if the man is positive but the wife has not had a test.

Discuss the possibility of encouraging sexual partners to have an HIV antibody test.

An HIV positive test result can result in sexual problems for either partner. The person may feel too afraid of infecting their partner to engage in sex at all.

See *Making a risk reduction plan*, section 4.4.

Making decisions about informing partners, family and other supportive people

KEY FACTS

- When someone discovers that they are infected with HIV, they face a difficult decision about whether to tell anyone.
- Disclosure is a process and not an event. It is a major decision that can have consequences for the person living with HIV and those around him or her. It is important that people do not rush into disclosure, but think it through carefully and plan ahead. Planning allows the client to imagine what may happen when he or she tells different people about their status and how they will control it.

This section is adapted from 'Counselling Guidelines on disclosure of HIV status' produced by the Southern African AIDS Training (SAT) Programme. See resource list.

BENEFITS OF DISCLOSURE	POSSIBLE NEGATIVE CONSEQUENCES
<p>Disclosure may help people to:</p> <ul style="list-style-type: none"> ■ Accept their status and reduce the stress of coping on their own and keeping a secret. ■ Access medical services, care and support. ■ Protect themselves and others. Openness about HIV status can help women to negotiate for protected sex. ■ Protect their children from HIV infection through mother to child transmission. ■ Influence others to avoid infection. ■ Reduce stigma, discrimination and denial as more people talk about their HIV status. ■ Take responsibility and plan for the future, including partners and family members. 	<ul style="list-style-type: none"> ■ The stigma attached to HIV and AIDS can result in negative consequences, especially in the short term. ■ Problems in relationships, perhaps with sexual partners, family and friends, community members, employer or work colleagues. ■ The experience of rejection and being judged. This may include abuse, violence, murder, rejection and abandonment. ■ Women are at greater risk of violence, abuse and rejection if they disclose HIV positive status than men, even if their partner infected them or they are in discordant couples. In pre-marital testing, an HIV positive test result may result in the marriage being stopped. ■ Pressure to assist in AIDS work and become a role model.

Steps towards disclosure

- Help the client to take time to think things through. Never judge people or put any pressure on them to tell others. Protect them from pressure from others and make sure that they want to tell people.
- Help clients to realise that it may be easier to tell one or two trusted people at first. Discuss sexual partners and children who need protection from HIV if appropriate.
- Help clients to understand what might happen if they tell inappropriate people or groups about their status.
- Help clients to make a plan for telling others. This should cover who they will tell first and later, how and where they will tell them, how much they will say and preparations.
- Discuss what different peoples' reactions might be immediately and afterwards. Prepare clients for shocked or hostile reactions. These are common but usually turn to acceptance with time. They will need to assess how much the person understands about HIV and AIDS. This will help them to decide what they need to tell the person and how to tell it so that it is less traumatic for both of them.
- Role-play telling different people with the client or using an 'empty chair' to represent the person. Invite the client to role-play the person being told so that they can empathise with the person and imagine the best way to go about it. The role-plays also act as a rehearsal and give the client confidence.
- Help the client to feel strong enough to allow others to express their feelings and concerns after they have been told.

Making decisions about having children

- Help HIV positive clients to decide what to do about having children. If they decide to postpone or not have children, help them decide which contraceptive to use.
- If clients want to conceive or are pregnant, discuss how anti-retrovirals (ARV), if available, could help them to reduce the risk of infection in the baby and slow their own infection.
- Pregnant women might wish to discuss the possibility of termination if it is legal at the number of months of the pregnancy.

See Section 8, *Counselling on the Prevention of HIV Infection to Pregnant Women, Mothers and their Children.*

Helping clients with HIV infection to live positively

- Explain that many people with HIV infection have learned to live positively and this has helped them to stay well and productive for a longer time.
- Living positively means living as normally as possible and looking after your health, psychological and other needs.
- Discuss the following ideas with clients and help them to make plans for living as positively as possible.
 - Try to eat meals containing energy foods such as cereals and tubers; oil and butter; body-building foods such as beans, nuts, seeds, fish, meat, eggs and milk; and fruits and vegetables to provide vitamins and minerals.
 - Continue with work as long as you feel able to.
 - Take enough rest.
 - Try to stop smoking and only drink alcohol in moderation.
 - Find ways to reduce stress. Do things you enjoy to relax and spend time with friends and family.
 - Seek spiritual support.
 - Seek treatment for infections promptly.
 - Explore the possibility of having anti-retroviral (ARV) treatment to slow down the infection with the client.
- Preparing for the future can help people to feel more positive and in control. Help your clients to prepare for the future.
- Helping others to protect themselves from HIV through education and condom distribution can make people with HIV feel valued and positive. However, it is important not to pressure them to take this role.
- Help people not to feel guilty about their HIV status.



Post HIV-Test counselling

A 31-year-old female client came for counselling on the 22nd October, 2001. She looked quite well, except that she had a minor rash on the face, which looked more like heat rash. After introductions, the client told her story. She was married in 1995 and was a virgin when she got married. Her husband had an HIV antibody test in 1992, before they got married. He had several sexual partners. After they married his health deteriorated. He had kept his status a secret, and his wife only discovered when he became unwell. Unfortunately, he had not disclosed his status to her and throughout the 4 years of their marriage, they had not practiced safer sex. The chances were that the wife was already infected. In 1999 the husband died, and the wife then decided to have an HIV test and it was positive. She had received counselling from other counsellors, but what is hurting her is that the person whom she loved and committed herself to betrayed her. Her in-laws feel she is the one who infected their son and her husband excluded her from the will. Now she has developed opportunistic infections and does not have enough money to seek medical services.

We were still continuing with the counselling session, when she got a call from work, so she had to leave. But she promised to come back within a week. From my observation, she looked like she had accepted her HIV status, although what has upset her is the fact that her spouse may have infected her and not included her in his will and enlisted his brothers over her.

- This case is an example of belief in the on-going myth that if a man is HIV positive, he can cleanse himself if he has a sexual encounter with a virgin.
- Also there is an unfounded traditional belief that if a man gets an STI or dies, the woman is responsible. This could explain why the wife ended up with nothing.
- She needs to come for further counselling and seek help from lawyers concerning the estate left by her husband.

6.4**Counselling clients with a negative test result**

- Help clients to understand that a negative result only means that the test has not detected any antibodies. Help them to consider the possibility that they could be infected and not yet showing antibodies to HIV.
- Ask clients whether they have engaged in any risky sexual activity over the past three months. If they have, suggest that they avoid any risky sex from now on and have another test in three months time or longer. They should act as if they are HIV positive until they get the results of repeat test.
- Give all clients the opportunity to repeat the test to be sure of the result if they wish.

Psychological support

Clients may respond in a range of ways to a negative test result. Do not assume that clients will react with relief and happiness to a negative test result.

The risk reduction plan

- If the client made a risk reduction plan at pre-test counselling, talk it over and ask: *“How do you feel about your risk reduction plan now? Do you need to revise it?”*
- If clients tell you that they will stay safe by not having sex anymore, acknowledge their intention, but help them to have sufficient skills and a plan to protect themselves if they do have sex.
- For clients who came for a test without their sexual partners, discuss whether they intend to tell their partner that they were tested and how they will discuss safer sex or testing with their partner if necessary.
- When a woman is HIV negative and the sero-status of her partner is unknown, the woman needs support to stay negative. If she can tell her partner and use this as an opportunity to encourage him to have a test also, this can be a big motivation for them both to practice safer sex from now on. The same thing applies if the man is negative.

Ask:

- What are the immediate actions that you must take to maximise the chance of remaining HIV negative?
- What skills and means do you need to achieve the risk reduction plan?
- What are the barriers to carrying out the risk reduction plan successfully?
- What help do you need in order to carry out the actions in the risk reduction plan (for example, help with partner notification)
- Do you need additional counselling?



"I'd had sex before and I was sure I had HIV so I didn't care about anything. Then I had an HIV test and found I don't have HIV. I'm so happy. I will never risk HIV again. I'm planning for a future I never thought I'd have."

6.5 Counselling when the test result is not clear

Sometimes the results of the test do not tell whether the test is positive or negative. This is frustrating for the client. This occurs rarely and may be because the person is in the pre-sero conversion phase. In this case, they should have a repeat test.

- Ask the client when they were last at risk of HIV infection. Ask them to come for a repeat test three months or longer after this date.
- Explain that the client needs to take the same precautions for reducing risk as a person testing HIV positive until the time of the repeat test.

6.6 Making referrals

The type and number of referrals you make depends on the services you can offer and the range of local facilities accessible to people in different economic groups. You may not have enough counsellors or skills to do intensive therapy over many sessions with negative people who continue to get tested; positive people who continue to practise risky sex or people with long-term sexual problems. Clients may require services, which you do not offer, such as treatment for STI or HIV; ante-natal care, termination of pregnancy, psychological counselling, legal help or a refuge. Make a map of your area and put on it all the facilities that you know about for different needs. If new support groups or other facilities become available, add them to your map. Try to visit the facilities so that they know you and your work, and you understand what they can offer your clients.

How to make a good referral

- Ask your clients which places they prefer, what their experience has been of different places, any barriers to following through with the referral and what would make it easier for them to go. Explain in detail what they can expect from the referral and if it helps, give them a note to take to the provider.
- Ask clients if they intend to follow through with the referral. If not, find out why and try to help them.
- Give your clients a written list of facilities, including if appropriate telephone numbers, addresses, hours of operations and services provided.
- Write the referrals in clients' records. If you make a referral, ask clients whether they were satisfied with the service and what help they provided.

Aims:

- To understand the dynamics of clients' sexual relationships in order to help them minimise the risk of abuse in safer sex practice and impact on sexual and reproductive health.
- To challenge and change harmful cultural and gender norms in relationships and increase awareness of rights.
- To offer support to abused clients and refer them when appropriate.
- To build on clients' skills and ability to take action on abusive situations.

This section focuses on abuse in sexual relationships rather than sexual abuse of children or rape crisis. See Resources for more information on these aspects of abuse. This section is adapted from the SAT booklet on 'Domestic Violence'. See Resource list.

Both women and men can suffer from abuse related to sex, but generally men abuse women. For this reason, we refer to the abused person as 'she' and the abuser as 'he', whilst recognising that males may also be abused by other men or women.

7.1

What is abuse in a relationship?

KEY FACTS

- **Physical abuse** involves physical assault. It includes hitting, punching, kicking, pulling hair and throwing things at someone. It can result in permanent injury, disability and death. In most cases men use it to frighten women so that they can control them.
- **Sexual abuse** is where a person forces another to have sexual intercourse or other activities against their will; inflicts pain during sex or does not allow the partner to use contraception or protection against STI/HIV. This can result in emotional trauma, illness and death.
- **Sexual harassment** includes making unwanted sexual comments, touches or propositions.
- **Psychological abuse** includes threats of suicide, violence or taking the children away, destruction of property or precious things or making a person perform degrading or dangerous acts.
- **Economic abuse** includes keeping partners short of money for basic needs, stopping her getting a job or forcing her to do sex work; controlling the money and spending it on his own desires; destruction of property and undermining partner's attempts to improve education.
- **Economic exploitation** includes manipulating someone to have sex they don't want with the offer of material rewards, jobs or basic needs.

Any of these forms of abuse can take place at home, in the workplace, in school, in public places or in religious institutions.

Sexual cultures and gender norms vary across ethnic groups and abuse, violence and coercion are viewed in different ways. In some cultures, married women are obliged to have sex with their husbands, whether they like it or not and rape in marriage does not exist in law; and men have a right to beat their wives if they step out of line.

However, cultures are changing continuously and most countries have signed up to human rights agreements that everyone has a right to choice in sexual activity and to be protected from violence. Counsellors have a role in changing culture and promoting human rights and laws through counselling and linking up with health promotion activities and activist groups.

- What do local norms say about forced sex and violence?
- What agreements has your country signed about human rights and sexual and reproductive health?
- What policies are in place concerning sexual and reproductive rights?
- What laws are there to protect people in relation to sexual and reproductive health?

Make yourself a summary of national agreements, policies and laws that you can refer to when you are counselling.

KEY FACTS

- In 95% of cases, the abuser is known to the abused and women are most likely to be abused at home.
- Women do not like to be forced to have sex they do not want. If a woman is crying, looking terrified or unhappy, she is not enjoying sex.
- Provocative clothes do not cause rape. Babies and elderly women are raped, most women who are raped are wearing everyday clothes that do not provoke.
- Getting aroused without having sex does not harm men. Men can switch off arousal by thinking about or doing something else. They may get pain in their testicles but this goes away without harming them.
- Nobody deserves to be physically hurt, however they behave. There is no excuse for violence.
- Abuse is not a sign of love. It hurts and damages the person being abused and kills love. You do not damage the person you love.
- Sexual abuse happens between people of all races, cultures, sexual orientation, economic status, religion, age and ability.
- It is difficult for women to leave abusive relationships for many reasons. These include economic dependency, fear, nowhere else to go, fear of losing the children and breaking up the family and unwillingness to admit that the marriage is not working and lose the status of a wife.

Many people do not know these facts and use misconceptions about abuse as an excuse for it. This makes it hard for survivors to get the support and help they need. They also make women blame themselves and not demand their rights. You can discuss these issues with survivors, families and communities and help to challenge their own misconceptions about themselves and their situation.

7.2

The Impact of Abuse on Sexual and Reproductive Health

Links between abuse and STI/HIV, unwanted pregnancy and pregnancy mishaps include:

- Forced vaginal or anal sex easily tears the lining of the vagina or anus and this makes it easier for HIV or STI to be transmitted into the body.
- Women fear rejection and violence if they discuss ways to protect themselves from STI including HIV and partners refuse to use condoms consistently or at all.
- Men who know that they have an STI or HIV do not tell their wives or girlfriends.
- Women are blamed for bringing HIV and/or STI into a relationship. If they disclose their HIV status, they risk scorn, rejection and violence.
- Many married women are forced to have sex with their husbands in spite of fears about pregnancy or HIV.
- Many married women are infected with HIV by their husbands.
- For many girls, first sex is forced. HIV incidence is six times higher in girls than boys.
- Women fear discussing, or are unable to use, contraception or natural family planning methods to plan their pregnancies; they have unplanned pregnancies leading to unsafe abortions or higher risk in childbirth. Refusal to have sex because of a wish to avoid pregnancy is a common cause of violence.
- Abused women are more likely to have miscarriages and premature births.
- Women who are abused suffer from gynaecological symptoms such as chronic pelvic pain more frequently.

7.3

Helping clients to talk about abuse

- **Be aware** that any one of your clients may be in an abusive relationship or have been abused and this will affect how you can help them. Spousal consent policies or discussions about condoms may put abused women at risk of violence. A pregnant 14-year-old girl or a woman with chronic pelvic pain may have been raped.
- **Look out for symptoms of abuse and screen** clients for physical or sexual abuse, provide initial counselling and refer them to available services.

Symptoms of abuse include:**Visible physical injuries**

Bruises, cuts, fractures, bites
Unexpected miscarriage or premature birth
Unexplained delay in seeking help for injuries

Illness

Stress-related illnesses
Anxiety-related illnesses.

Other problems

Marital, Family and sexual problems,
Depression, Suicidal thoughts, Alcohol or drug problems,
Mental health problems,
Low self-esteem,
Taking responsibility for abusers actions,
Feeling guilty and denying terror and anger.

■ Open up the conversation about the client's sexual relationship

In the explore of REDA or the ask of GATHER, section 2.3 learn about the client's sexual relationship and history. Use questions like:

- *What might make it difficult for you to protect yourself from unwanted pregnancy and infection?*
- *How might your partner respond if you talk to him about contraception or safe sex?*
- *Does your partner want sex more often than you want it? Has he ever pressured or forced you to have sex when you didn't want it?*
- *What happens if you say that you do not want to have sex?*
- *Has your partner or anyone else tried to physically harm you in any way?*
- *Did you have any upsetting experiences in childhood or adolescence?*

With this understanding, you can help your client in the most appropriate way.

For example, explore together ways to minimise the risk of abuse when using contraception or talking about safer sex practices or disclosing an STI or HIV result.

Reaffirm confidentiality by making sure that the client knows that what she or he says will not be repeated elsewhere. This is crucial because it can prevent further harm to the client. You need to get permission from the client before you refer her or him to another service, for example, a doctor or the police.

7.4**Ways you can help your client to become empowered**

Even if you cannot refer an abused client or offer much practical help, you can empower the client by:

- **Believing her story:** Listen actively, ask questions, empathise and avoid making judgements or giving advice.
- **Building on her strengths:** Complement her on what she has achieved so far, her coping strategies and survival skills. For example, in coming to see you. Help her to build on these strengths.
- **Validating her feelings:** Abused women often have mixed feelings about the abuser – for example, love, anger, hope, fear, sadness and guilt. Give the woman time and support to let out all her feelings. Let her know that they are normal and reasonable.
- **Avoid blaming her for the situation:** reinforce that the abuse is not her fault – it is the responsibility and problem of the perpetrator. Resist the temptation to criticise his personality, talk instead about his behaviour.
- **Take her fears seriously:** Listen and empathise with the client's fears and worries. Take them seriously, do not judge how serious a problem is. Discuss options to overcome these fears and worries.
- **Offer help:** Offer specific and appropriate forms of help and information. Do not make false promises and end up not being able to meet her needs.

7.5**Giving practical help**

Network and refer clients to appropriate local services and groups. Link up with local services and women's groups. Provide information about these services in your clinic or talk to women in the community about them. Invite experienced people to train your counsellors and staff on helping abused women.

Pregnancy

- Help your client to talk with her partner about contraception if she wishes. Offer couple counselling or counselling for her partner. Provide print materials if appropriate.
- Help your client to use a contraceptive without her partners' knowledge if she feels that this is the only solution. Discuss potential difficulties, for example, changes in menstruation.
- Provide emergency contraception if the client has had unprotected forced sex within the past 72 hours.

My nearest source of emergency contraception is:

- Offer a pregnancy test and discuss termination if it is legal and the client is interested.

STI and HIV

See Sections 4 and 5.

- Explore ways to talk with the partner about safer sex and rehearse them if appropriate. Consider asking other people to help, for example, a relative or friend of the partner.
- Consider the use of female condoms or microbicides, if available.
- Discuss having tests for STI and/or taking antibiotics.
- Discuss the HIV test and the use of prophylactic anti-retrovirals drugs if available.

The abusive relationship

- Discuss which trusted people might support the client to cope with the situation and make a plan for disclosure if appropriate.
- Discuss going to a lawyer and/or the police to take legal action.
- Discuss options to prevent or end an abusive situation and help the client to decide on the best course of action.

Options might be:

- To leave the partner and situation and live with a supportive person or in a refuge;

My nearest refuge is:

- To obtain more support from others in changing the partner's behaviour, for example, community leaders, mediators, friends or relatives.
- Counselling the perpetrator individually or as a couple.
- Small group counselling or skills building activities to explore relationships, communication and ways of improving them.



- Recognising and avoiding or addressing triggers which result in abuse, for example, alcohol.
 - Supporting the client to ask the law to intervene.
 - Building the client’s support network to put pressure on the abuser to change and to respond in abusive episodes.
 - Link up with or initiate community work aimed at changing sexual and gender norms. For example, Stepping Stones in the Gambia stopped or greatly reduced wife beating and helped men to accept that women have a right to refuse sex. (Welbourn, A. 1995)
 - Counsel the members of the abused person’s family also.
- Consider the pros and cons of each option. This will help the client to make an informed decision. Do not expect a quick solution to the problem of abuse, even if you feel frustrated. It often takes time for a woman to work through her feelings and options. Even then, she may decide that the best option is to stay in the abusive relationship and do nothing.
 - Explore the effects of all the partner’s forms of controlling behaviour on the client. Do not hold the client responsible for the abuse in any way or encourage her to change as a way of getting the abuser to change.
 - Be prepared to challenge your own attitudes and ideas about abused clients.
 - Support the client to choose what action she wants to take. Agree on a follow-up and feedback strategy before she leaves. Can she come back for another session? Can she contact the counsellor or can the counsellor contact or visit her? It is important to make the client feel that she is supported.

Be an active, creative partner in the woman’s safety planning efforts.

If you are concerned about the client’s safety, express your concern without judgement.

You could say

“From what you are telling me, I feel that your situation is dangerous and I am concerned about your safety. Do you think that is right or not?”

You can then discuss with her safety plans. Take the problem, consider the full range of options, discuss the risks and benefits of each option and how the risks can be reduced. Provide ideas, resources and information but always encourage the woman to take responsibility for her well-being and safety.

Incest/sexual abuse

A 14-year-old girl came with an aunt. They had come for a pregnancy test. On further probing, it became evident that the girl had been raped. According to the history given, the girl was raped on her way home from a night church service. There was some suspicion that the perpetrator was someone known to the girl.

The aunt was so defensive and one concluded that probably the perpetrator was well known to her. They were advised to report the incident to the Police and Swaziland Action Group Against Abuse (SWAGAA) so that the girl could receive counselling while the Police tracked down the culprit.

The girl when interviewed alone claimed that she did not see the rapist, but kept crying whenever the counsellor asked if it was a relative. The aunt was so restless and impatient. She insisted that they had come for a pregnancy test and abortion services. Should that fail, they would go back home and report before taking the matter to the Police or any other organisation. Consequences of silence after sexual abuse were explained to them.

The pregnancy test was positive and the counsellor referred them to SWAGAA for the rape case. It was doubtful if they would go there. This case confirms the common practice of the unwillingness to report abuse cases even at the expense of the children’s lives and well being. There is a need to work with other organisations to change this situation.

Aims

- To help clients to understand what actions they can take to prevent the transmission of HIV to their children.
- To assist women and men to make a decision on whether to conceive or not.
- To assist women and men to minimise the risk of HIV infection during conception and pregnancy.
- To provide information on the extra risk of transmission to the child if mother is infected during pregnancy or breast-feeding.
- To assist parents to make an informed decision on whether to have an HIV antibody test.
- To assist mothers (and fathers) to decide whether to continue a pregnancy or terminate it.
- To help mothers and families to weigh up the benefits and risks of different infant feeding options.

8.1

HIV transmission from mother to child and methods of prevention

KEY FACTS

HIV can be transmitted from an infected mother to her child during pregnancy, delivery and breast-feeding. Transmission ranges from 15-25% in rich countries to 25-45% in resource poor countries. The extra risk of HIV infection when an infant is breast-fed is around 15%. There are a number of interventions that can reduce the risk of transmission to as low as 10%. The health, well-being and sexuality of mothers as women is important, so counsel them on all the issues of safer sex when they attend services, not just pregnancy and preventing transmission to the child.

The prevention of HIV transmission to Pregnant Women, Mothers and their Children (PMTCT) includes:

- The prevention of HIV infection in women, mothers and mothers-to-be;
- The prevention of unwanted pregnancies;
- The prevention of HIV transmission from the infected mother to the infant.

The prevention of HIV in men and women of child-bearing age is a very important strategy for individuals, couples and communities as well as counsellors. Safe sexual behaviour and fast treatment of STI greatly reduces risk of transmission to children. Men have a major responsibility to practice safe sex and inform their female partners if they are at risk of STI. Women need awareness of the benefits of condoms and the ability to negotiate safer sex. Family planning counsellors are key to the prevention of unwanted pregnancies. Making contraceptives, emergency contraception and safe abortion, accessible to all women, rich or poor, young or old, unmarried or single would reduce the rate of transmission to infants.

Prevention of transmission of HIV through pregnancy and breast-feeding involves:

- STI screening and treatment.
- Accessible, high quality Voluntary Counselling and Testing (VCT) for mothers and fathers.
- Safe sex during pregnancy and breast feeding.
- Prophylactic treatment by anti-retroviral drugs.
- Avoidance of invasive obstetrical procedures.
- Alternatives to early mixed feeding and prolonged breast feeding.
- Safe sex after delivery to prevent unwanted pregnancies.

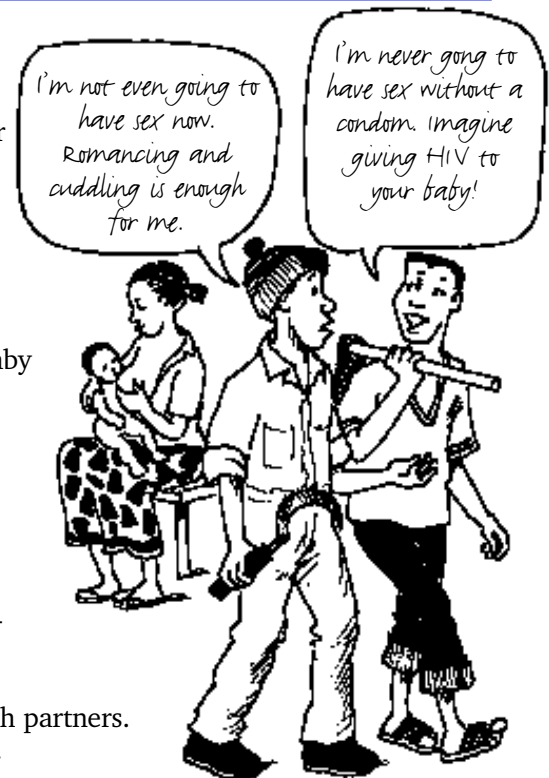
These options require high quality ante-natal care (ANC) and VCT, care during delivery, post-natal care for mother and child and counselling on infant feeding.

If VCT is promoted, it is an ethical imperative to ensure that women who are HIV positive have access to long-term care and support. The advantages of VCT before, during and after delivery depend on the availability of treatment, the possibility of safer sex and support.

8.2 Counselling clients on HIV/AIDS who are considering conception

Some women and men may wish to know their HIV status before considering conception. Some women and men who know that they are HIV positive may wish to discuss issues around having a child before they consider pregnancy. Some women and men who have lost their babies due to HIV may wish to have another child. Counselling before conception could include:

- Voluntary testing for one or both partners
- Counselling on the positive and negative points in conceiving at this time
- Counselling about reasons for wanting to conceive a baby when the woman and/or her partner is HIV positive.
- Minimising the risk of HIV transmission in becoming pregnant.
- Risks of mother to child transmission and options to prevent PMTCT.
- Increased risk of PMTCT if HIV contracted during pregnancy and breast-feeding.
- Long-term outcome for mother and baby, including ill-health, stigma and loss of parents.
- STI diagnosis and treatment.
- STI and HIV prevention in pregnancy, safer sex for both partners.
- Need to attend early for antenatal care to benefit fully.



8.3 Counselling pregnant women and their partners

Safer sex

If a mother is infected with HIV during pregnancy or breast-feeding, the risk of transmission to the infant is high because the amount of virus in the blood and milk is high. STI in pregnancy also increase the risk of PMTCT.

Counsel women, and if possible, their partners during pregnancy and lactation, so that they understand the importance of avoiding HIV infection and STI and put risk reduction plans in place. See section 4.4.

Pre-test counselling

Women at ante-natal clinics have the same rights to informed consent and need the same pre-test counselling as clients in any other setting. See Section 1.2. Help them to think through the advantages and disadvantages of testing in relation to the baby as well as their own lives. Do not promote testing and be honest about the support that you can offer if the result is positive.

ADVANTAGES

- Know, understand and are helped to cope with HIV status.
- Empowered to make good choices about having the baby or termination.
- Access to appropriate health care for mother and child.
- Access to information about negotiating for safer sex.
- Support with prevention of HIV transmission (for those testing negative and positive).
- To help partner share her HIV status.
- Gain access to ongoing support (social and emotional) through shared confidentiality.

DISADVANTAGES

- Emotional distress.
- Stigma.
- Abuse or abandonment by partner.
- Breached confidentiality.
- Frustration if no treatment or support is available.

Counselling if the woman is positive

Telling partners about the test result

It is often particularly difficult for a woman tested at the ante-natal clinic to inform her partner she is positive soon after getting the result. Her partner and family may blame her for bringing the infection into the family although the status of her partner is unknown and he may have infected her. This can have a long-lasting negative impact on her psycho-social and economic well-being and family life. Testing at ante-natal clinics can make people see HIV and AIDS as a woman's disease.

In some settings, counselling and testing partners together is very helpful. In others, couples do not wish to be tested together. It is important to provide VCT in settings where men feel comfortable. In Thailand, men often accompany their wives to the ante-natal clinic and they receive information followed by counselling together. If the husband does not attend, the wife is helped to invite him to the clinic for VCT. Involving the male partner helps to avoid blaming the woman for HIV.

Some women involve relatives such as sisters, mothers or 'aunties' in the VCT process. This can make follow-up care, including strategies to avoid PMTCT, easier. It may also result in isolation and stigma.

Counselling on continuation of pregnancy

Women who test HIV positive in early pregnancy in countries where abortion is safe and legal, may wish to discuss whether to continue the pregnancy or have a termination.

Explore the following questions with the client or couple.

- What are the risks that the child will be infected? How can the parents reduce this risk?
- What impact will the pregnancy have on the mother's health?
- How many other children does the client have? What is their health and HIV status?
- What support is available to the mother and family?
- What does the pregnancy mean to the client?
- What are the client's feelings and values about termination?
- What impact might termination have on her health?
- What will the termination cost and who will pay for it?
- What methods of contraception has the client used before and what method would she like to use after the pregnancy or termination?

8.4

Counselling HIV positive clients to prevent Mother to Child Transmission

Anti-retroviral (ARV) drug treatment

Talk to clients about the available treatment and care options for prevention of Mother to Child Transmission so that they can make informed decisions relating to their pregnancy.

If you can offer or refer for ARV treatments, informed consent, detailed explanations, monitoring and follow-up are particularly important, as the procedure is complex. It may involve a number of different services, including family planning and infant feeding support. It is essential that the client takes the drugs correctly. You can help the client to do this if you understand the regime, the risks and benefits.

Mothers who have ARV treatment should not breast-feed their infants because the drug goes into her breast milk and may harm the baby. The feasibility and safety of alternative infant feeding in the mother's particular circumstances may determine whether she decides to have ARV treatment.

The number of infants of mothers receiving short course ARV treatment who contract HIV is greatly reduced to around 10%. These infected infants need continuing medical care and they, their mothers and families need social and emotional support.

Options to prevent Mother to Child Transmission include:

Antiretroviral drugs (ARVs), AZT (zidovudine), Nevirapine, Combination therapy, Malaria prophylaxis, Multivitamins/vitamin A.

Refer to 'HIV in Pregnancy: A Review UNAIDS 99.35E

Infant feeding options

KEY FACTS

- HIV can be transmitted from mother to child through breast-feeding.
- The extra risk of HIV infection when an infant is breast-fed is around 15%.
- HIV transmission during breast-feeding is increased by the factors in the following table which also shows ways to reduce risk.

FACTOR INCREASING RISK	WAYS TO REDUCE RISK
<ul style="list-style-type: none"> ■ Recent infection with HIV during pregnancy or while breast-feeding 	<ul style="list-style-type: none"> ■ Counsel mother or couple about safer sex during pregnancy and breast-feeding.
<ul style="list-style-type: none"> ■ The mother has AIDS 	<ul style="list-style-type: none"> ■ If the mother develops AIDS during pregnancy or breast-feeding, try to find a replacement food
<ul style="list-style-type: none"> ■ Infection with STIs 	<ul style="list-style-type: none"> ■ Screen and treat mothers for STI. Counsel on safer sex.
<ul style="list-style-type: none"> ■ Vitamin A deficiency 	<ul style="list-style-type: none"> ■ Provide Vitamin A supplements or teach mother how to obtain from local foods.
<ul style="list-style-type: none"> ■ Cracked or bleeding nipples or breast abscess 	<ul style="list-style-type: none"> ■ Counsel on management of breast-feeding and treat.
<ul style="list-style-type: none"> ■ Other foods and drinks given with breast-milk 	<ul style="list-style-type: none"> ■ Give only breast-milk with no other food and drink, including water, for the first 6 months. Stop breast-feeding completely at 6 months and switch to other foods/substitutes
<ul style="list-style-type: none"> ■ Longer duration of breast-feeding 	

Infant feeding from birth to six months

Breast milk is normally the best food for an infant. If the mother is HIV positive, replacement feeding may be best to reduce the risk of HIV transmission. However, for each mother, the health risks of replacement feeding should be less than the risk of HIV infection.

As noted in Section 8.4 ARV drug treatment, if the mother is considering ARV to prevent Mother to Child Transmission, explain that if she chooses to have ARV treatment, she should not breast-feed her infant because the drug goes into her breast milk and may harm the baby. The feasibility and safety of alternative infant feeding in her particular circumstances may determine whether she decides to have ARV treatment.

These risks are shown in the table below with some ways of reducing them. If these cannot be put in place, it may be less risky for the infant to breast-feed exclusively for the first six months if this is possible.

RISKS OF REPLACEMENT FEEDING IN FIRST SIX MONTHS	HOW TO REDUCE RISK
<ul style="list-style-type: none"> ■ Malnutrition 	<ul style="list-style-type: none"> ■ Ensure that family have enough breast-milk substitute for six months.
<ul style="list-style-type: none"> ■ Infection 	<ul style="list-style-type: none"> ■ Teach hygiene rules that will work in living conditions of mother.
<ul style="list-style-type: none"> ■ High cost 	<ul style="list-style-type: none"> ■ Subsidise or provide free.
<ul style="list-style-type: none"> ■ Loss of child spacing 	<ul style="list-style-type: none"> ■ Counsel the couple on contraception.
<ul style="list-style-type: none"> ■ Loss of mother-child bonding 	<ul style="list-style-type: none"> ■ Counsel the parents/family on ways to give child attention.
<ul style="list-style-type: none"> ■ Stigmatisation of mother 	<ul style="list-style-type: none"> ■ Counsel partner and family to support mother. ■ Work to change community attitudes.

From birth to six months, milk in some form is essential for an infant. If not breast-fed, an infant needs about 150 ml of milk per KG of body weight a day.

Breast-milk substitutes:

Commercial infant formula, Home-prepared formula,
Unmodified cow's milk

Modified breast-feeding:

Stop breast-feeding early, Expressed and heat-treated milk

Other breast-milk:

Breast-milk banks, Wet-nursing

Before you start counselling on infant feeding, find out as much as you can on what options are available in your locality and how safe they are likely to be, the social and economic conditions and local infant feeding practices.

Counselling both parents and/or other members of the family may make it easier for the mother to choose the best way to feed her infant without fear of stigma, if they can accept her HIV status. Find out as much as you can about the following questions and discuss them with your client(s).

■ **What breast-milk substitutes are available in the first six months of the baby's life?**

These might be commercial infant formula, home prepared modified animal milk, dried milk powder or evaporated milk or unmodified cow's milk. Non-commercial breast-milk substitutes should only be considered when families do not have access to commercial substitutes. If they are not using commercial formula, they will need to learn how to modify the milk and to give micro-nutrient supplements.

Skimmed and sweetened condensed milk, yoghurt, fruit juices, sugar water and dilute cereal gruels are not suitable for feeding infants under six months of age.

■ How much do they cost as a percentage of the family income? Are there any free sources?

■ Will the mother have access to sufficient substitute for at least six months?

■ Does the family have water, fuel, utensils, skills and time to prepare the substitute accurately and hygienically?

■ How will the partner, family and community respond if the mother does not breast-feed her baby? Has the mother disclosed her HIV status to her partner or family or does she plan to?

Families with enough income or access to free commercial breast-milk substitutes to provide sufficient milk for six months, with a good water supply, sanitation system, and supportive family and community members are most likely to be able to stop breast-feeding and give substitutes safely.

Breast-feeding

If the mother chooses to breast-feed, it is best to give breast-milk only with no other liquids, including water, or foods because this prevents infection of both HIV and other diseases. If breast milk and substitutes are given, the baby is more at risk from both HIV and other infections.

It has been found that exclusive breast-feeding for six months and then completely stopping reduces Mother to Child Transmission. Mothers with HIV infection could consider this as an option if they:

■ Find it difficult for social reasons to avoid breast feeding altogether.

■ Develop symptoms of AIDS during the breast feeding period.

■ Can only provide safe and adequate replacement feeds after their baby is six months old.

■ **Heating breast-milk** kills HIV. Expressing and heat-treating breast milk is time consuming and may not be a practical option for mothers at home.

■ **Breast milk banks** are not an option for meeting infant needs over a long period. They need to have high standards of screening and pasteurising for the milk to be safe.

■ In **wet-nursing**, there is a risk of HIV infection from wet-nurse to infant and from infant to wet-nurse, if either is infected with HIV. Clients should only consider it if the wet nurse has an HIV test and is uninfected; she is informed of the risks; she practises safer sex; she can breast feed the infant frequently enough and she has access to support to avoid cracked nipples.

Feeding children aged six months to two years

Breast-milk continues to be an important source of nutrients from six months to two years. If the mother stops breast-feeding at six months to reduce the risk of HIV infection, family foods need to be enriched with protein, energy and micro-nutrients and given five times a day.

- What foods are available to the household at different times of the year from the farm or garden and from the market?
- How can the mother combine these foods to give the infant all the nutrients he or she needs?
- How can family members make sure that the child eats enough?

8.5**Helping families with HIV infection to plan for the future**

Women with HIV often worry about what is going to happen to their children if they become sick or die. These worries are not specific to women testing during the antenatal period but health workers must be open to discussing them at this time.

Women may need help with planning for the future and advice to help them prevent “property grabbing”. They may be anxious or depressed about what the future holds, especially if they have seen friends or relatives dying from AIDS. Health workers should keep up to date about the existing and potential availability of ARV drugs to treat the mother in the longer-term. They should be able to refer for spiritual and legal support (for preparing wills etc.) if available.

A last word...

In this guide we have tried to provide you with basic information on ways in which you can integrate counselling on sexuality, STI and HIV, relationships and abuse and the prevention of HIV transmission to babies into your family planning counselling. This is a challenging task but the rewards in terms of happier and safer sexual relationships, protected fertility, better health and the prevention of HIV in parents and their children are immeasurable.

The promotion of improved sexual health involves addressing the underlying factors that cause sexual problems including poverty and gender inequality. It requires the improvement of relations and communication between men and women, a greater understanding and acceptance of our sexuality and the ability to talk about these areas of life. Your important role as a counsellor will be enhanced if you can work with the community to address these issues or form partnerships with those who do.

Managers have an important responsibility to ensure that their counsellors are committed and adequately trained, appreciated and supported, given the time and resources to do a good job and enabled to learn continuously from their successes and mistakes.

As counsellors, you will gain a greater understanding of yourself and other people through your partnership with your clients and enhance your skills and personal qualities as you work to provide a high quality service.

Resource list

Materials from the Southern African AIDS Training Programme

The following are pocket-sized user-friendly booklets on specific AIDS topics. Copies may be obtained from:

Southern African AIDS Training Programme
3 Luck Street
PO Box 390 Kopje
Harare, Zimbabwe
Tel: 263 4 781123
Fax: 263 4 752609
e-mail info@sat.org.zw

- Counselling Guidelines on Disclosure of HIV Status. South African AIDS Training (SAT) Programme. 2001
- Counselling Guidelines on Domestic Violence. SAT Programme April 2001
- Counselling Guidelines on Child Sexual Abuse. SAT Programme. 2001
- Counselling Guidelines on Palliative Care and bereavement SAT April 2001
- Basic counselling guidelines in HIV and AIDS. SAT July 2001.
- Guidelines for counselling children affected by HIV and AIDS. SAT. August 2001

Materials from UNAIDS, available from their website www.unaids.org

UNAIDS Technical Update (May 2000) '*Voluntary Counselling and Testing (VCT) HIV and Infant Feeding. A Guide for health-care managers and supervisors.* UNAIDS/98.4

Counselling and voluntary HIV testing for pregnant women in high prevalence countries. Guidance for service providers. May 1999.

Materials from Academy for Educational Development from website <http://hivinsite.ucs.edu>

Fundamentals of HIV Prevention Counselling: Participants Manual 1998.

Other materials

Zimbabwe HIV Prevention Counselling Training Manual.

Gordon, G. and Gordon, P. (1992) '*Counselling and Sexuality: A Video Based Training Resource*'. IPPF London.

The Bangkok Collaborative Perinatal HIV Transmission Study Group.(1999) '*Counselling Pregnant Women and New Mothers about HIV*'. Produced by the HIV/AIDS Collaboration, Thailand.

Rinehart, W., Rudy, S. and Drennan, M. '*GATHER Guide to Counselling*' Population Reports, Series J. Number 48. Baltimore, Johns Hopkins University School of Public health, Population Information Program, December 1998.

What's Sex Got To Do With It? www.popcouncil.org/publications/pdfs.html

Ndondo, Noziqhu. T. (2001) '*Preventing mother-to-child transmission of HIV. A training manual for healthcare providers.*' Reproductive Health Alliance, London

EngenderHealth '*STI/HIV Prevention – Quick Reference Cards for Health Care Providers – What Every Client Should Know*'. (2001) New York.

Welbourn, A. (1995) '*Stepping Stones: A Training Package on HIV/AIDS, communication and relationship skills*' Strategies for Hope.



**International
Planned
Parenthood
Federation**

IPPF Central Office
Regent's College,
Inner Circle, Regent's Park,
London NW1 4NS, UK
Telephone: +44 (020) 7487 7900
Fax: +44 (020) 7487 7950
Email: info@ippf.org
Website: www.ippf.org