Module 2

Sub module 1: Orientation to counselling

Sub module 2: Counsellor values and attitudes

Sub module 3: Counselling microskills

Sub module 4: HIV testing

Sub module 5: Role of VCT in HIV prevention and care

Sub module 6: Post-HIV test counselling

Sub module 7: Suicide risk assessment in HIV and management

Module 2

Sub module 1: Orientation to counselling

Session objectives

At the end of the training session, trainees will be able to:

- Define counselling
- Describe the difference between counselling and client education
- Define HIV/AIDS counselling
- Discuss the aims and importance of HIV/AIDS counselling
- Discuss the counselling process

Time to complete sub module

1hour 30 minutes

Training materials

- PowerPoint presentation **(PPT05)**
- Activity sheets **(AS04 & AS05)**
- Handout **(H05)**
- Question box
- Evaluation form collection box

Content

- Definition of counselling
- Difference between counselling and client education
- Definition of HIV/AIDS counselling
- Aims and importance of HIV/AIDS counselling
- Methods of support
- Stages of behavioural change

Session instructions

1. Commence session by opening PowerPoint presentation **(PPT05)**.
2. When prompted in the PowerPoint presentation, ask trainees to brainstorm their own definition of counselling and HIV/AIDS counselling.
3. Activity **(AS04)**
   - At the commencement of the session, ask trainees to rate their commitment to daily exercise. Also ask them to interview other trainees in the room and find out their exercise habits.
   - Group of 4-5 persons to brainstorm on:

What helped them move from level 1 to their current level?
What prevented them from moving to level 5 (where exercise is done regularly)?
For those who exercise regularly (level 5), ask them to discuss:
What helped them move to level 5?
What helped them maintain their exercise habit?

- Summarise the key points and lecture on factors that determine behaviour.

4. Activity **(AS05)**
   - Present case of Ratree
   - Ask trainees to discuss problems of Ratree
   - What is the role of the counsellor? How will you help her solve her problems?
   - Summarise key points and lecture on why we need counselling in HIV/AIDS and define VCT.
5. Give the summary of the session.
6. Complete the PowerPoint presentation **(PPT05)**.
7. Ask the group if they have any questions and remind them about the “question box”.
8. Ask trainees to complete an evaluation form and place in the “evaluation form collection box”.

Module 2

Sub module 1: Orientation to counselling

Session objectives

At the end of the training session, trainees will be able to:

Define counselling
Describe the difference between counselling and client education
Define HIV/AIDS counselling
Discuss the aims and importance of HIV/AIDS counselling
Discuss the counselling process

What is counselling?[1]

Counselling has been defined as a process of helping a person/people learn how to solve certain interpersonal, emotional and decisional problems.

A counsellor's role is to help the client help himself or herself.

Counselling can be done with an individual or with couples or families.

Aims of counselling

Counselling aims to help each individual take charge of his/her own life by:

- Developing the ability to make wise and realistic decisions
- Altering their own behaviour to produce desirable consequences
- Providing information

Counselling IS …

- Client-centred — specific to the needs, issues and circumstances of each individual client
- An interactive, collaborative and respectful process
- Directed towards developing autonomy and self-responsibility in clients
- Considerate of interpersonal situation, social/cultural context, readiness to change
- Asking questions, eliciting information, reviewing options and developing action plans

Counselling IS NOT …

- Telling or directing
- Giving advice
- A conversation

- An interrogation
- A confession
- Praying

How is counselling different from health education?[2]

Counselling	Health education
Confidential	Not usually confidential
Usually a "one- to- one" process or small group	Small or large groups of people
Evokes strong emotions in both counsellor and client	Emotionally neutral in nature
Focused, specific and goal-targeted	Generalised
Information used to change attitudes and motivate behaviour change	Information used to increase knowledge and educate
Issue-oriented	Content-oriented
Based on needs of the client	Based on public health needs

What is HIV/AIDS counselling?

HIV/AIDS counselling is a confidential communication between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions relating to HIV/AIDS. The counselling process includes the evaluation of personal risk of HIV transmission, the facilitation of preventive behaviour and evaluation of coping mechanisms when the client is confronted with a positive result (World Health Organisation).

Why is HIV/AIDS counselling important?

- Prevention counselling and behaviour change can prevent transmission
- HIV diagnosis has many implications – psychological, social, physical, spiritual
- HIV is a life-threatening illness and it is lifelong

Aims of HIV/AIDS counselling

HIV/AIDS counselling is a process with three general objectives:

1. Providing psychological support, i.e. support which is concerned with emotional, psychological, social and spiritual well-being for people who have contracted the virus and for others affected by the virus.

2. Preventing transmission of HIV by providing information about risk behaviours (such as unsafe sex or needle sharing) and assisting people to develop personal skills necessary for behaviour change and negotiation of safer practices.

3. Ensuring effective use of health referral, treatment and care by problem-solving treatment adherence issues.

The counsellor achieves these aims by :

- Allowing the person to identify and express their feelings (Often they cannot do this with anyone else.)

- Exploring options and assisting clients to develop action plans for issues of concern
- Encouraging behaviour change as appropriate
- Providing up-to-date information on HIV/AIDS prevention, treatment and care
- Informing the person about resources and agencies (government and non-government) that can assist with the social, economic and cultural difficulties that may arise because of HIV
- Helping the person contact the agency (It is part of the role of a counsellor to maintain awareness and good communication with all community agencies. The patient's permission should be obtained before referral to the outside agency.)
- Helping the patient draw support from their social network, family and friends
- Assisting clients to adjust to grief and loss that inevitably occurs where there is illness, loss of husband, wife or partner, loss of friendship or other loss such as income, housing or employment
- Taking on an advocacy role – e.g. helping to fight discrimination
- Alerting individuals to their legal rights
- Helping the patient to maintain control over their lives
- Helping the patient to discover a meaning for their life

HIV/AIDS counselling should address the physical, social, psychological and spiritual needs of the person

That means we must always consider:

- The problems of infection and illness
- Death, bereavement
- Social discrimination
- Sexuality
- Lifestyle
- Prevention of transmission

It is important to note that in addition to the issues directly related to HIV, clients may be presented with a range of issues that are pre-morbid or indirectly related to HIV.

Specific therapy may be required to assist clients with pre-morbid or co-existing psychiatric illness such as manic depressive illness, or specific problems such as sexual dysfunction, management of sleep difficulties, panic attacks, etc.

HIV may also re-activate previously unresolved issues such as sexuality issues, sexual identity issues (homosexual or bisexual), guilt or shame for working as a sex worker, drug addiction or family problems unrelated to HIV.

Methods of support

1. **Individual education** of client about safer behaviours. Exploration and problem solving around the individual's difficulties in practicing safer behaviours.

2. **Welfare** assessment and referral for welfare needs, including income, housing, employment, childcare and guardianship matters (with client's permission).

3. **Client advocacy**
   a. Liaison with health care providers to ensure client attains all services: Referral to medical follow-up, including TB and STI management programmes, family planning, welfare, and psychosocial care. Liaison with NGOs and other governmental agencies (with client's permission).

b. Assist clients in addressing discrimination issues and documenting for legal matters.
c. Community development work and advocacy. Ensure counsellors participate in general government committees, e.g. housing, social security, education in schools, etc., to keep the needs and issues of HIV on the agenda and ensure that they are considered in the broader community service planning.

4. **Assisting the medical staff,** e.g. problem-solving around poor treatment adherence – clients often hold personal beliefs about medications, based on folklore or what they observed happening when friends took the drug, e.g. assisting medical staff in managing suicidal behaviour in clients.

5. **Psychological support to PLWHA and significant others, e.g.** psychological reactions to infection, change in health status. Psychological interventions to assist in managing mood disturbance resulting from the HIV infection or the psychosocial circumstances surrounding the disease.

   Clinical interview to assist in diagnosis and management of dementia and AIDS-related neuropsychiatric disorders, e.g. mania, psychosis and co-morbid or pre-morbid psychological conditions.

   Support can be provided to the families, partners and friends of people with HIV who may have difficulty adjusting to a partner's diagnosis and want advice on how to emotionally support the HIV-positive person. Other issues may relate to fear of sex with an infected partner, and anger at the partner for having placed them at risk.

   Group work, family therapy and child play therapy are all methods of support that should be considered.

6. **Neuropsychological assessment**—HIV can cause significant changes in the central nervous system, which may result in significant cognitive, psychiatric and neurological conditions. Refer to neurologist and/or clinical psychologist and psychiatrists, if they are available, to assist with:
   a. Differential diagnosis
   b. Early identification (often function loss will show up in psychological tests that do not appear on CT scan, MRI, etc.)
   c. Quantifying severity of dementia
   d. Documenting response to treatment
   e. Establishing mental competency for legal matters, e.g. wills, guardianship, treatment decisions, etc.

7. **Supervision and training**—Counsellors can provide emotional support, debriefing and casework supervision to other health care workers, peer group facilitators and volunteers.

   Counsellors are often involved in training volunteers in communication skills, emotional support and referral information.

8. **Research**—Counsellors can contribute to HIV prevention and treatment programmes by conducting behavioural research into various areas, including transmission, risk-taking behaviour, sexuality, adjustment and psychosocial issues in HIV.

9. **Education**—Work in HIV demands psychosocial education. Counsellors can assist in training medical and nursing staff to be sensitive to the psychosocial needs of their patients. Training could be offered in a variety of areas including enhancing communication with patient relationships, and being sensitive to, and aware of, patient's psychosocial issues.

   Counsellors can also contribute to raising community awareness of the psychosocial needs of people with HIV and the impact of discrimination.

   By utilising behavioural research, counsellors can also assist in general education programme planning.

10. **Policy development in health and community policy planning; networking, policy development and client advocacy**—Getting "invited" to participate in planning for other government programmes. In Australia, counsellors have contributed to policy and planning to keep HIV on the agenda and ensured that psychosocial issues are considered.

Government (examples)	Non-government/private companies (examples)
Defence forces (HIV policy)	Volunteer agencies, e.g. home care
Employment developments	Insurance and superannuation
Housing	Peer support groups
Social security	Company workplace policies
Health	Real estate companies (services to clients with HIV)
Immigration and foreign affairs	
Police	
Corrective services (prisons)	
Education, schools, universities	
Children's services (welfare)	
Discrimination board	
Parliamentary legislation (re: HIV)	
Sexual assault services	
Guardianship board – legally mandated care for children, intellectually/mentally incompetent, etc.	

Counselling process[3]

STAGE ONE

Forming rapport and gaining the client's trust

- Assuring confidentiality and discussing limits of confidentiality
- Allowing ventilation
- Allowing expression of feelings
- Exploring the problem(s), asking the client to tell their story
- Clarifying client expectations of counselling
- Describing what the counsellors can offer and their method of working
- Statement from the counsellor about their commitment to work with the client

STAGE TWO

Definition and understanding of roles, boundaries and needs

- Explaining roles and boundaries of the counselling relationship
- Establishing and clarifying client goals and needs
- Prioritising client goals and needs
- Detailed history taking – telling the story in specific detail
- Exploring client beliefs, knowledge and concerns

STAGE THREE

Process of ongoing supportive counselling

- Continued expression of thoughts and feelings
- Identifying options
- Identifying existing coping skills
- Development of further coping skills
- Evaluating options and their implications
- Enabling behaviour change
- Supporting and sustaining work on client problems
- Monitoring progress towards identified goals
- Altering plans as required
- Referral as appropriate

STAGE FOUR

Closure or ending the counselling relationship

- Client acting upon plans
- Client managing and coping with daily functioning
- Existence of a support system and supports being accessed
- Identification of strategies for maintenance of change
- Closure discussed and planned
- Appointment intervals lengthened
- Available resources and referrals identified and accessed
- Assurance provided to the client of the option to return to counselling if necessary

Reference

[1] Nelson-Jones R. (1988). Practical counselling and helping skills: Helping clients to help themselves. Holt, Rinehart and Winston: Sydney, pp. 13 - 35
[2] Ministry of Health and Family Welfare, National AIDS Control Organisation, Government of India, HIV/AIDS Counselling training manual for trainers
[3] Adapted from: Ministry of Health and Family Welfare, National AIDS Control Organisation, Government of India, HIV/AIDS Counselling training manual for trainers, pp. 82-83 and Family Health International (2001), Zimbabwe HIV Counselling training manual, pp.49-51.

Module 2

Sub module 2: Counsellor values and attitudes

Session objectives

At the end of the training session, trainees will be able to:

- Appreciate the importance of counsellor self-awareness
- Appreciate that different people hold different values
- Appreciate that counsellors need to respect clients irrespective of their culture, race, religion, etc.
- Address or modify attitudes that may negatively impact the client-counsellor relationship
- Appreciate the importance of maintaining confidentiality in counselling service delivery

Time to complete sub module

2 hours

Training materials

- PowerPoint presentation **(PPT06)**
- Activity sheets **(AS06, AS07, AS08 & AS09)**
- Handout **(HO6)**
- Evaluation form collection box

Content

- Attributes of an effective counsellor
- Impact of counsellor values and attitudes on clients
- Confidentiality in counselling
- Managing uncomfortable client situations

Session instructions

1. Lecture with PowerPoint presentation **(PPT06)**. Conduct the activities as prompted in the presentation.
2. Brainstorm activity**.** Qualities and attributes of a good counsellor – 10 minutes
   - Ask trainees to refer to **HO6**
   - Ask the trainees to brainstorm on what they think are the qualities of a good counsellor
   - List the points while the discussion is taking place
   - The facilitator should try to elicit as many qualities as possible from the trainees. At the end, go over the list in the presentation and add any qualities that have not been mentioned by the trainees

3. Activity **(AS06)**. Values – 10 minutes
   - Using **AS06**, ask the trainees to rank the items in terms of their value to them
   - Note that they should be ranked from 1 to 7 with 1 being of most importance and 7 being of least importance
   - Divide the trainees into small groups and ask them to discuss why they made their ranking choice
   - Emphasise that differences within the group are due to different values
4. Activity **(AS07)**. Controversial statements – 15 minutes
   - Ask trainees to remain in their small groups
   - Using **AS07**, ask the trainees to fill in the blanks, using an A for "agree" and D for "disagree"
   - Ask them to discuss some of the differences within their group
   - Emphasise that differences within the group reflect different values, attitudes and beliefs
5. Activity **(AS08)**. Listing of words – 15 minutes
   - Ask trainees to remain in their small groups
   - Using **AS08**, ask trainees to list two words that come to their mind spontaneously when they think of the listed words. Ask them to list words that reflect their emotional response to the given word instead of a mere translation or definition of the word. For example, two words for sex may be: 1. Fun; 2. Immoral
   - Ask them to discuss some of the differences within their group
   - If time permits, the facilitator can take all the worksheets, and one by one ask trainees to take any one sheet at random, read out the responses to any one trigger word and discuss whether the listed words are primarily positive or negative. All trainees must get the opportunity to read out and discuss the responses to at least one trigger word and the whole list must be covered. The trainer takes note of the responses and uses his/her observations to summarise with the group how different words are perceived and reacted to emotionally. Allow 30 minutes for this particular activity
6. Activity **(AS09)**. Managing your discomfort – 20 minutes
   - Ask trainees to refer to **HO6**
   - Lecture on the causes of discomfort emphasising the fact that people look at different situations differently
   - Explain why people behave or react differently to the same situation
   - Illustrate the concept using common issues like seeing a dog and either feeling frightened and threatened or feeling like getting closer and patting the dog
   - Ask trainees to refer to **AS09**
   - Ask trainees to complete the activity recalling an occasion where they felt uncomfortable with a client. Ask them to imagine that they are experiencing that particular occasion again and to answer the questions on the activity worksheet
   - After making notes under each of the questions, ask trainees to discuss their experience of the exercise with a partner
7. Ask the group if they have any questions and remind them about the "question box".
8. Ask trainees to complete an evaluation form and drop it in the "evaluation collection box".

Module 2

Sub module 2: Counsellor values and attitudes

Session objectives

At the end of the training session, trainees will be able to:

Appreciate the importance of counsellor self-awareness
Appreciate that different people hold different values
Appreciate that counsellors need to respect clients, irrespective of their culture, race, religion, etc.
Address or modify attitudes that may negatively impact the client-counsellor relationship
Appreciate the importance of maintaining confidentiality in counselling service delivery

Qualities and attributes of a good counsellor

CONFIDENTIALITY is vital. At all times respect the confidentiality of what is disclosed to you. Do not fall into the trap of easy gossip. There is nothing more calculated to destroy your credibility than this. It will also cause distress to the person you are working with. Lack of confidentiality will make a mockery of the whole process of counselling.

Effective counsellors need to command the respect of the person(s) being counselled but should not be so far removed from them so as to inspire awe or fear. Key qualities of a good counsellor include:

- **Genuineness**. This is an important part of the communication process. The genuine person is one who is simply him/herself, without facade. A genuine relationship between counsellor and client is the basis of successful counselling. Genuine interest is also reflected in your body language

- **Listening**. Listening involves attending to the client's verbal and non-verbal messages. As a counsellor, the way you respond is effectively dependent on how you listen. The way you listen plays a big part in encouraging or discouraging a client to keep talking. Only when one has listened can one empathise

- **Unconditional positive regard**. Sensitivity, respect, friendliness and consideration are effective as counselling ingredients. Showing personal warmth is basic in any relationship

- **Believing the client**. Be able to communicate to the client that you believe him or her. For the client, it is very comforting to realise that someone understands how they are feeling

- **Cultural sensitivity**. Respect the client's cultural and belief systems. Be sensitive to cultural contexts and traditions. Culture informs people on how they do things and when they do them.

Acknowledge differences, explore beliefs and ask questions to increase understanding and optimise assistance provided

- **Showing the way**. Help the client think of various alternatives available to them and work with them to consider the advantages, disadvantages and implications of each alternative. Do not, however, take responsibility for the client's problems as this can create dependency and helplessness

- **Honesty**. Recognise your own limitations and refer them to another expert source, if possible. If you do not know something tell, your client. Counsellors need to have self-awareness of their own issues and the ability to prevent them from influencing the counselling relationship

- **Patience**. Move at the client's pace — do not rush him or her. Make sure adequate time is provided for the counselling process. Some issues might be too sensitive or maybe he or she is not sure yet whether to trust you or not

- **Free expression**. Do not block free expression of feelings, e.g. crying, anger, etc. Blocking free expression of feelings can be due to pressure of work — the counsellor has other clients waiting – or maybe the counsellor is uncomfortable with the expressed emotions. If the counsellor is under pressure, it is important to remember that the most important person at any given time is the client you have right in front of you. You need to work with them first before moving to the next client. If you are getting uncomfortable with the expressed emotions, could it be that you have your own unresolved issues?

- **Non-judgmental**. Avoid falling into the trap of taking sides and deciding who is right and who is wrong. You are there to listen and not to judge. You need to demonstrate acceptance

- **Being in control**. Stay focussed and do not wander all over the place. This usually happens if you are following content – enjoying the interesting bits of the story – and not following the process

- **Empathetic**. This is the ability to see the problem as the client sees it, yet at the same time, standing back and objectively observing what is happening with the client and the counselling relationship

- **Knowledgeable**. It is essential to have accurate and up-to-date knowledge. Counsellors should be well informed about the field they work within, including the services and resources available to their client group within their setting and community

Attitudes, values and beliefs

We are all influenced by the society and culture within which we live, develop and mature.

Society and culture contribute to the development of personal attitudes, values and beliefs.

Our attitudes, values and beliefs:
- Guide day-to-day behaviour
- Influence our interpretation, explanation and response to events
- Are usually specific to the culture in which they evolved
- Vary between and within countries, regions and groups[1]

Table 1: Qualities of good counsellors

Qualities of a good counsellor	Good counsellors should stay away from
Qualities perceived in the counsellor that can help the client feel secure enough to engage in self-exploration:	• Pushing or threatening the client
	• Offering their opinion
	• Judging the client or their lifestyle
• Self-confidence	• Telling a client they "know" how they feel
• Empathy	• Imposing your own beliefs
• Acceptance	• Sidestepping the client's present problem
• Genuineness	• Minimising the client's problem
• Trustworthiness	• Interrupting
• Confidentiality	• Taking responsibility for the client's problem and decisions
• Competence	• Becoming immersed in the client's situation
	• Using words such as "should" and "must"
	• Blocking strong emotions

Counsellor self-awareness: addressing attitudes, values and beliefs

Counsellors need to develop a self-awareness of their attitudes, values and beliefs.

Counsellors further need to consider and examine how attitudes, values and beliefs may impact upon how we live our lives and specifically how we conduct our work. They need to know how they may respond when they are confronted with clients who hold different opinions to their own.

Counsellors are required to work with people of different backgrounds – different races, cultures and religions. Counsellors need to recognise and accept that all people are different, and may hold attitudes, values and beliefs different from their own.

Counselling is NOT pushing people to conform to certain "acceptable" standards to live by. Effective counselling must therefore take into account the impact of values, attitudes and culture on the client's perception of the world.[2]

Good counsellors do not allow their own attitudes, values and beliefs to influence the counselling process.

Difficulties and conflicts in counsellor-client attitudes, values and beliefs should be addressed through supervision, consultation with experienced counsellors, and if necessary, referral.

Counsellor self-awareness in relation to HIV/AIDS

Our different backgrounds influence our attitudes and beliefs about HIV/AIDS.

Counsellors need to be sensitive to the client's world and culture and how HIV/AIDS may be perceived within the client's world and culture.

Counsellors should also explore with their clients, prevailing beliefs about illness, HIV infection and counselling.[3]

Questions counsellors may like to ask themselves:[4]

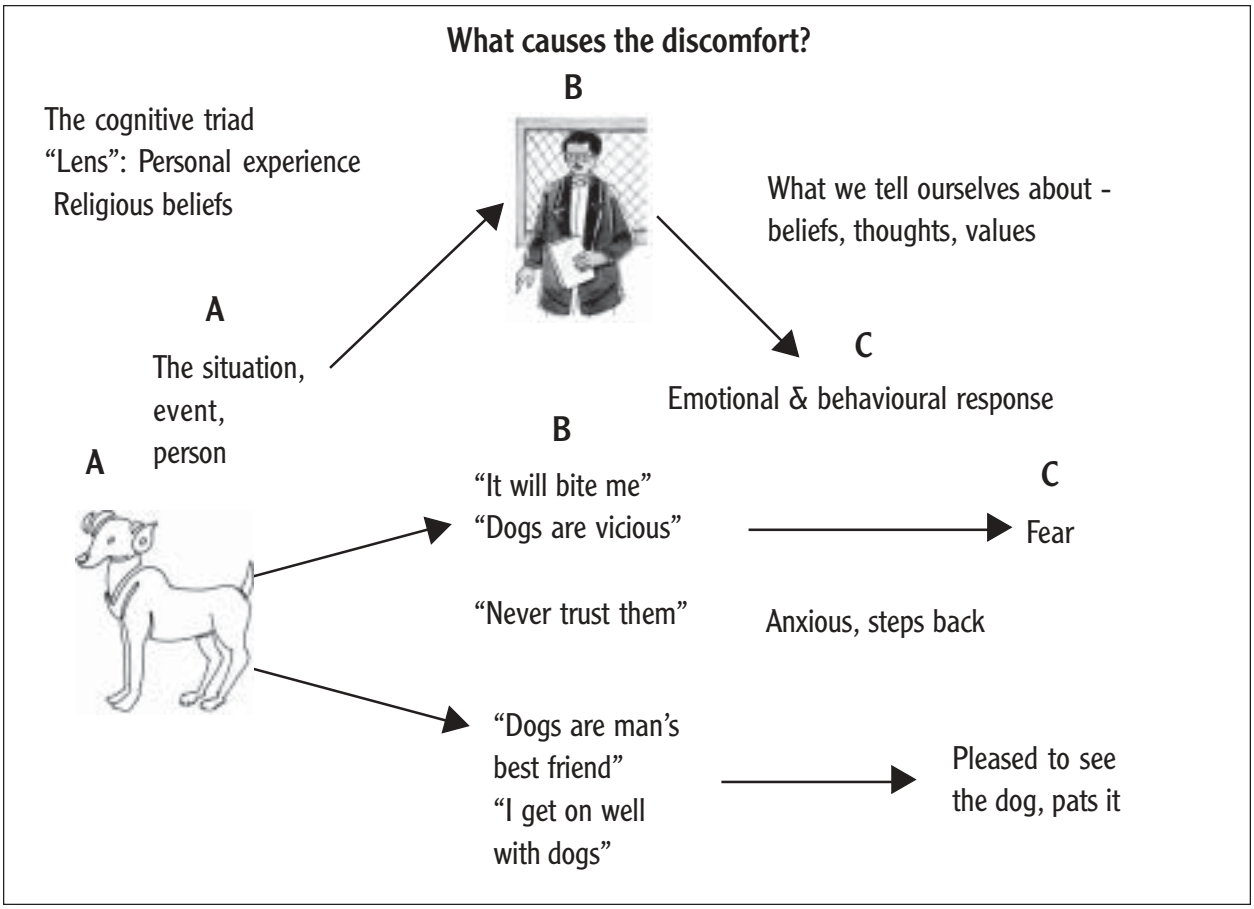
- What are my own feelings about people whose behaviour has placed them at risk of infection?
- What are my own feelings about people with HIV infection or AIDS?
- Am I afraid, critical or overwhelmed?
- In view of the ways in which the infection is sometimes contracted, can I treat certain persons as fellow humans, or will I see them as being at fault and immoral?
- Which sexual practices would be most difficult to talk about, given my own personal and cultural values?
- What everyday/slang words would I use, or never use, to explain risk practices or behaviour, especially to clients who differ from me racially, culturally or sexually, or are much younger or older?
- Can I use my own values of individual worth and dignity as benchmarks for everyone, even if my client's cultural background and way of life are very different from mine?
- How would I explain the need to discuss behaviour that is seen as strange or deviant in a particular society or culture?
- In this culture, to what extent am I ready to let clients do what they decide to do and take responsibility for their own care?
- Will I involve others in decisions if it is the accepted thing to do, or always try to be in control?
- How much do I want to influence, control or dominate other people?
- Are there some kinds of people or types of behaviour of which I disapprove so strongly that I probably could not counsel those concerned competently?

When our personal values conflict with our duty – managing counsellor discomfort

Our emotional and behavioural responses to situations are determined by the way we think about situations. Our thoughts are derived from our social and behavioural conditioning. Our thoughts and beliefs are determined over a lifetime and are influenced by past experiences, culture, religion, parenting and peer influences. The diagram that follows demonstrates this process.

In the diagram two different people see the same dog and have two different sets of emotional and behavioural responses. One person responds warmly and attempts to pat the dog. This person has had life experiences that have led him/her to believe that dogs are man's best friend and are no threat. The other individual experiences fear and backs away as he/she has had negative direct and indirect experiences with dogs. The dog is the same dog — only the thoughts of the individuals about the dog are different.

This theory is derived from cognitive behavioural therapy (CBT). The theory is that we can modify our behavioural and emotional response to situations, people and events by changing or challenging our thinking. The idea is not to change your core value system but rather modify the intensity of the response. Using the example in the diagram we can modify the level of fear by confronting the fearful individual with evidence that not all dogs which he or she has seen bite people. Similarly, we can induce a little caution into the person who thinks all dogs can be patted without risk.



CORE STEPS to changing our emotional and behaviour by changing our thinking

Often in the course of our work as counsellors, we may be exposed to client situations that confront our values in such a way that it may negatively influence our emotional and behavioural response to clients. The effectiveness of our work as counsellors can be adversely affected if we do not control strong negative emotional and behavioural reactions to clients and their situations. We are not seeking to modify your core value, which may be different to the client, but rather we are seeking to have you look at the situation in a different way. By changing your thinking about the situation you may modify the intensity of your emotional and behavioural response so that you can achieve the goals of your counselling.

Follow these steps:

1. Ask yourself, *"What am I feeling right now?"*
2. Ask yourself, *"What am I telling myself about the client or their situation?"*
3. Follow this by asking yourself, *"What is another way to think about this?"*

Challenge your thoughts with questions such as:

- "How do I know this?"
- "What are the possible reasons that the client might engage in these behaviours or situations e.g. poverty, child abuse history, etc.?"
- "Could there be other explanations or options?"
- "What is another way of looking at this?"

4. What am I here for? (Aims of counselling) *How best can I achieve these goals?*
5. Debrief later with a colleague and do some self-care. Discuss the situation, how you felt about the situation, what you did and how you feel now that you have completed the work with the client, but do not reveal the identity of the client.

Post-client self-care for the counsellor

Counsellors can adversely respond to clients if they do not take responsibility for managing their stress level. Absenteeism, work avoidance and chronic illness can all be manifestations of counsellor stress.

There are two types of stress release:

- Active – physical release by intense physical activity. This is particularly useful for reducing anger and frustration
- Passive – meditation and other relaxation techniques which can assist with nervousness, fatigue or sleep difficulties

Other strategies for managing work-related stress:

- Debrief with a colleague or supervisor (while maintaining client confidentiality)
- Success recording — challenge yourself to record what you did achieve
- Journal writing
- Other personal self-care strategies

Activity: Values[5]

Please rank the following in terms of their value to you. In small groups discuss why you have made your ranking choice. Note that they should be ranked from 1 to 7 with 1 being of most importance and 7 being of least importance.

Health _____

Pleasure _____

Freedom _____

Sexuality _____

Family _____

Control _____

Career _____

Activity: Controversial statements[6]

Fill in the blanks — A for “agree” and D for “disagree”.

1. _____ Women with HIV infection should not have children.
2. _____ People with AIDS should be allowed to continue work.
3. _____ AIDS is mainly a problem of people with immoral behaviour.
4. _____ Men who have sex with men indulge in abnormal sexual behaviour.
5. _____ People with HIV infection should be isolated to prevent further transmission.
6. _____ It is a collective responsibility to care for people with HIV infection.
7. _____ I would feel uncomfortable inviting someone with HIV infection into my house.
8. _____ Surgeons should screen all patients for HIV infection before surgery.
9. _____ I would feel uncomfortable discussing sexuality with a person of the opposite sex.
10. _____ Injecting drug users should compulsorily be tested for HIV.
11. _____ It is all right for men to have sex before marriage.
12. _____ School children should not be educated about safer sex.
13. _____ Women should never have extra-marital sexual relations.
14. _____ All professional blood donors should be jailed.
15. _____ It is difficult for male counsellors to talk to women clients about condom use.
16. _____ HIV-infected pregnant women should abort their foetus.
17. _____ HIV test results should not be disclosed to the spouse/partner.
18. _____ Males should produce an HIV-free certificate before marriage.
19. _____ HIV-infected women should feed their infants.
20. _____ Unmarried persons should not have sex.

Activity: Listing of words[7]

List two words that come to your mind spontaneously when you think of the following words. As far as possible, list words that reflect your emotional response to the given word instead of a mere translation or definition of the word. For example, two words for sex may be: 1. Fun; 2. Immoral.

Sex worker	1._____	2._____
Professional blood donor	1._____	2._____
Pregnancy	1._____	2._____
Injecting drug users	1._____	2._____
Teenager	1._____	2._____
Condom	1._____	2._____
Sexually transmitted infection	1._____	2._____
Homosexual	1._____	2._____
Masturbation	1._____	2._____
Wife	1._____	2._____
Boyfriend	1._____	2._____
AIDS	1._____	2._____
Truck driver	1._____	2._____
TB (tuberculosis)	1._____	2._____
Orgasm	1._____	2._____
Erection	1._____	2._____
Abortion	1._____	2._____
Rape	1._____	2._____
Multiple sex partners	1._____	2._____
Counsellor	1._____	2._____

Activity: Managing discomfort

- Form pairs. Each person is to take turns to share a negative client experience with his or her partner.
- Using the process described, see if you can modify the intensity of your negative feeling towards the situation.
- Your partner is to encourage you to look at the situation in a different way. for example, if you had a strong feeling of anger when you were confronted with a married man who has sex with other men, you would state you felt angry and rate that anger on a scale of 1-10 (10 being the strongest anger). Then with the help of your partner you would ask yourself what thinking produces the angry emotion. Then try to look at the problem following all of the steps described. At the end of the activity, rate the level of intensity of your anger again on the 1-10 scale and observe whether you have modified the intensity of your emotion.

1. What am I feeling right now?

2. What am I telling myself about the client or their situation?

3. What is another way to think about this? Challenge your thoughts with questions such as: *"How do I know this?"; "Could there be other explanations or options?"; "What is another way of looking at this?"*

4. What am I here for? (Aims of counselling)

5. What self-care can I do afterwards?

References

[1] Ministry of Health and Family Welfare, National AIDS Control Organisation, Government of India, HIV/AIDS counselling training manual for trainers
[2] Family Health International (2001). Zimbabwe HIV counselling training manual
[3] Family Health International (2001). Zimbabwe HIV counselling training manual
[4] Ministry of Health and Family Welfare, National AIDS Control Organisation, Government of India, HIV/AIDS counselling training manual for trainers
[5] Adapted from: Family Health International (2001) Zimbabwe HIV counselling training manual
[6] Adapted from: Ministry of Health and Family Welfare, National AIDS Control Organisation, Government of India, HIV/AIDS counselling training manual for trainers
[7] Adapted from: Ministry of Health and Family Welfare, National AIDS Control Organisation, Government of India, HIV/AIDS counselling training manual for trainers

Module 2

Sub module 3: Counselling microskills

Session objectives

At the end of the training session, trainees will be able to:

- Demonstrate effective client-counsellor communication skills

Time to complete sub module

3 hours

Training materials

- PowerPoint presentation **(PPT07)**
- Activity sheets **(AS10a, AS10b, AS11)**
- Handout **(HO7)**
- Question box
- Evaluation form collection box

Content

- Listening
- Questioning
- Silence
- Non-verbal behaviour

Session instructions

1. Opening activity in **(AS10a & AS10b)** pairs
   - Facilitators should allow 30 minutes in total: 10 minutes to explain activity; five minutes for pair activity; and 15 minutes for debriefing /discussion
   - Ask trainees to form pairs for an activity
   - Instruct them to nominate one person to be the 'counsellor' and the other to be the 'client'
   - Ask all the counsellors to meet together in one area of the training room for their instructions Provide them with the instructions for counsellors, as below (and give them a copy of **AS10a**). Ask them NOT to share this with their partners (i.e. the client)
   - Ask all the clients to meet together in one area of the training room for their instructions. Provide them with their 'client' instructions as below (and give them a copy of **AS10b**)
   - Instructions for *counsellors*:
     - Your job in this activity is to be a 'bad counsellor'
     - Ask your client to tell you about an achievement in their lives; a time they did something they were proud of and happy about
     - As your client begins to answer, demonstrate poor counselling skills, e.g. look at your watch, write notes, play with your hair, look around the room, look for something in your bag, fix your make-up, play with your jewellery, talk to someone else across the room,

interrupt and tell your own story, make inappropriate facial expressions, sit with a closed posture, look disinterested, do not encourage the conversation, do not ask questions, etc.
    - Remember that you need to be as bad as possible
    - DO NOT tell your client you have been asked to be bad – this must be kept confidential! The purpose of the activity will be explained afterwards and the clients will be told that you were asked to be 'bad'
  - Instructions for *clients:*
    - Your job in this activity is to be a 'client'
    - You need to think of an achievement in your life, a time you did something you were proud of and happy about
    - It should be something you are comfortable with and able to discuss for 5 minutes
    - The 'counsellors' will be practicing their basic skills during this activity
  - Ask everyone to find his or her partner and begin the activity
  - Allow the activity to proceed for 3-5 minutes – use your judgement as to how much time is needed as you observe whether pairs are continuing or ceasing conversations
  - Reassemble the group after the activity and ask the 'clients' to share their experiences
  - Explain that the 'counsellors' were asked to be 'bad' and that the purpose of the activity was to quickly highlight the importance of the basic skills of communication
2. Lecture with PowerPoint presentation **(PPT07).** During the presentation solicit comments and ask trainees questions to keep them involved actively in the presentation.
3. Group activity: *Listening*
  - Relate points to the discussion generated from the activity
  - Ask trainees to add further ideas for demonstrating active listening
4. Activity **(AS11):** *Questioning*
  - Ask trainees what types of questions they are aware of (answer: closed/open/leading)
  - Give the lecture **(PPT07)** on the different types of questions
  - Provide trainees with **(AS11)**. Give them a few minutes to review the questions listed and to circle the answer according to whether they are closed/open/leading
  - Review the questions as a large group – ask the trainees to say out loud the answers they have chosen. Discuss and correct answers where required
  - Refer to this guide as required:
    1. You always practise safer sex don't you?
       Closed *and* leading
    2. What are some of the difficulties that you would have using a condom?
       Open
    3. Do you take your medication?
       Closed
    4. You should tell your wife, shouldn't you?
       Closed *and* leading
    5. When were the occasions that you shared needles?
       Open
    6. What do you know about HIV?
       Open
    7. Do you understand how HIV is transmitted?
       Closed
    8. Do you protect yourself from HIV?
       Closed

9. What are the different ways you could protect yourself from HIV?
   Open
10. How do you clean your injecting equipment?
    Open
11. Have you ever had a blood transfusion?
    Closed
12. Who could you talk to for support if you were to test HIV positive?
    Open

5. Continue the lecture **(PPT07)** on:
   - Do's and don'ts of questioning
   - Silence: Discuss the importance of counsellors being comfortable with silence during counselling
   - Non-verbal behaviour: During this section of the lecture it is important to provide clear examples
     - Facilitators should try to 'act out' the body language and paralinguistic features of non-verbal communication
     - Choose a co-facilitator or participant to act as partner to demonstrate body orientation, body proximity/distance and mirroring
   - Quick reference
     - Bring to the trainee's attention the quick reference tables at the conclusion of **HO7**
6. Closing activity in pairs.
   - Facilitators should allow 30 minutes in total: 5 minutes to explain activity; 15 minutes for pair activity; and 10 minutes for debriefing/discussion
   - Ask participants to divide into the same pairs as for the opening activity
   - Ask them to repeat the activity, utilising the skills discussed in the lecture
   - Reassemble participants into the large group and ask them to reflect on the difference between the opening and closing activity
7. Summarise the key points of the session.
8. Ask the group if they have any questions and remind them about the "question box".
9. Ask trainees to complete an evaluation form and place it in the "evaluation collection box".

Module 2

Sub module 3: Counselling microskills

Session objectives

At the end of the training session, trainees will be able to:

Demonstrate effective client-counsellor communication skills

Counselling microskills are essential for effective communication and the development of a supportive client-counsellor relationship. As a foundation, counsellors need to develop specific microskills. These include:

- Listening and empathy
- Questioning
- Silence
- Non-verbal behaviour

Listening[1]

Good listening involves all of the following:

- Eye contact (culturally appropriate)
- Demonstrate attention, e.g. nodding
- Encouragement, e.g. *"Mm-hmm", "Yes"*
- Minimise distractions, e.g. TV, telephone, noise
- Do not do other tasks at the same time
- Acknowledge the client's feeling, e.g. *"I can see you feel very sad"*
- Do not interrupt the client unnecessarily
- Ask questions if you do not understand
- Do not take over and tell your own 'story'
- Repeat back the main points of the discussion in similar but fewer words to check you have understood the client correctly (this is known as paraphrasing, reflection of feelings, clarification, summarising)

"You seem to be saying ……."
"In other words, ……."
"You feel ……. because ……."
"You seem …….. What's happening for you? What are you thinking about?"
"I wonder if you are feeling ……. because …….?"
"Correct me if I am wrong, but ……."
"Let me check if I have understood you correctly. You ……., is that correct?"
"What I hear you saying is ……."

An important component of good listening skills is the ability of the counsellor to convey empathy. Empathy involves trying to understand how individuals view themselves or their world. Demonstrating empathy helps establish rapport with clients, and facilitates the client feeling "safe" to disclose the truth about their feelings and circumstances.

Empathy is conveyed by using all of the listening skills indicated earlier. In particular, the following techniques can be utilised:[1]

- **Paraphrasing**, which involves restating, in your own words, the essence of what the client has said. Paraphrasing assures the client that you are listening and it assists the client in focusing on his/her situation more clearly

Client: *"I feel so helpless. I can't get my housework done, get the children to school on time or even cook a meal. I can't do the things my wife used to do."*

Counsellor: *"You are feeling inadequate about doing things you have not had to do in the past when your wife was alive"*

- **Reflecting emotions:** This is similar to paraphrasing except the focus is on the emotions being expressed by the client. Reflecting emotions assists the client to become aware of how they are feeling, and to explore their reactions to events they are describing.

Client: *"I don't know what to do. Before he died, I promised my husband that I would take care of his mother for the rest of her life. But I no longer have the energy. I cannot seem to get my self sorted out to do anything. He knew that his mother and I did not get along and that the situation would be miserable. Why did he die and leave me in this mess?"*

Counsellor *"You seem to be feeling very low and helpless right now; but at the same time you seem to be feeling guilty and angry about your promise to your husband."*

Questioning[2]

Questioning is an important part of counselling. It helps us understand the client's situation and it helps us assess clinical conditions.

When asking questions:

- **DO** ask one question at a time
- **DO** look at the person
- **DO** be brief and clear
- **DO** ask questions that serve a purpose
- **DO** use questions to help the client talk about their feelings and behaviours
- **DO** use questions to explore and understand issues and to heighten awareness
- **DO NOT** ask questions simply to satisfy curiosity — irrelevant questions may cause people to feel pushed or reluctant to answer. Too much time may be spent thinking of questions rather than actively listening. Too many questions will be experienced as intrusive and similar to an interrogation

There are essentially three styles of questions:

1. Closed questions

A closed question limits the response of the client to a one-word answer.

e.g. *"Do you practice safer sex?"*
e.g. *"Do you know how to use a condom?"*

Closed questions may not require clients to think about what they are saying. Answers can be brief and often result in the need to ask more questions.

2. Open questions

An open question requires more than a one-word answer.

e.g. *"What difficulties do you experience in practicing safer sex?"*
e.g. *"How might you react if you received a HIV-positive test result?"*

Open questions generally begin with "what", "where", "how" or "when". They invite the client to continue talking and to decide what direction they want the conversation to take.

3. Leading questions

Leading questions are questions where the counsellor guides the client to give the answer they desire. These questions are usually judgemental.

e.g. *"You do practice safer sex, don't you?"*
e.g. *"Do you agree that you should always use a condom?"*

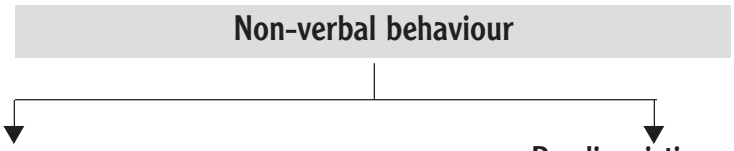
Silence

- Gives a client time to think about what to say
- Gives a client space to experience their feelings
- Allows a client to proceed at their own pace
- Provides a client with time to deal with ambivalence about sharing
- Gives a client freedom to choose whether or not to continue

Non-verbal behaviour[3]

It's not what you say but *HOW* you say it!

The majority of communication is non-verbal. Counsellors need to be aware of what they may be communicating to their clients through their non-verbal behaviour. They also need to give attention to what is being communicated through the non-verbal behaviour of their clients.



Body language
- Gestures
- Facial expressions
- Posture
- Body orientation
- Body proximity/distance
- Eye contact
- Mirroring
- Remove barriers (e.g. desks)

Paralinguistic
- Sighs
- Grunts
- Groans
- Voice pitch change
- Voice volume
- Voice fluency
- Nervous giggles

Quick reference for counselling microskills[4]

Examples of **supportive** behaviour in a selected culture:

Verbal	Non-verbal
Uses language that the client understands	Uses a tone of voice similar to the client's
Repeats the client's story in other words	Looks client in the eye (as appropriate)
Clarifies client's statements	Nods occasionally
Explains clearly and adequately	Uses facial expressions
Summarises	Uses occasional gestures
Responds to primary message	Keeps suitable conversational distance
Encourages: "I see", "Yes", "Mm-hmm"	Speaks at an appropriate pace
Addresses client in a manner appropriate to the client's age	Physically relaxed
Gives needed information	Open posture

Examples of **non-supportive** behaviour in a selected culture:

Verbal	Non-verbal
Advising	Looking away frequently
Preaching and moralising	Keeping an inappropriate distance
Blaming, judging and labelling	Sneering
Cajoling (persuading by flattery or deceit)	Frowning, scowling and yawning
"Why" questions, interrogating	Using an unpleasant tone of speech
Directing, demanding	Speaking too quickly
Excessive reassuring	Speaking too slowly
Straying from the topic	Having a blank facial expression
Encouraging dependence	Staring
Patronising (condescending) attitude	Moving around too much, fidgeting
Criticising or censuring	Environmental barriers or distractions

Participant activity handout: Questioning quiz

1. You always practise safer sex, don't you?	Closed / open / leading
2. What are some of the difficulties that you would have using a condom?	Closed / open / leading
3. Do you take your medication?	Closed / open / leading
4. You should tell your wife, shouldn't you?	Closed / open / leading
5. When were the occasions that you shared needles?	Closed / open / leading
6. What do you know about HIV?	Closed / open / leading
7. Do you understand how HIV is transmitted?	Closed / open / leading
8. Do you protect yourself from HIV?	Closed / open / leading
9. What are the different ways you could protect yourself from HIV?	Closed / open / leading
10. How do you clean your injecting equipment?	Closed / open / leading
11. Have you ever had a blood transfusion?	Closed / open / leading
12. Who could you talk to for support if you were to test HIV positive?	Closed / open / leading

References

1 Nelson-Jones R. (2nd Edition), Practical counselling and helping skills: Helping clients to help themselves, Holt, Rinehart and Winston: Sydney, pp. 13 – 35
2 Franchino, Lynda (1986) Basic counselling skill: A manual for trainers of bereavement counsellors. Cruse Publishing: Melbourne
3 Danish S., D'Augelli A., and Hauer A (1980), Helping skills: A basic training programme, 2nd edition, Human Sciences Press: New York, pp. 5 – 14
4 Adapted from Ministry of Health and Family Welfare, National AIDS Control Organisation, Government of India, HIV/AIDS counselling training manual for trainers, page 84

Module 2

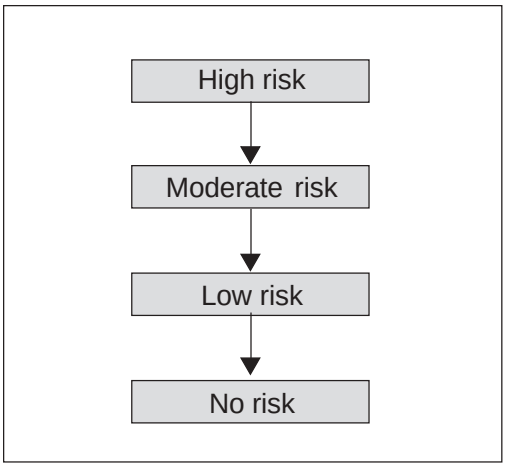
Sub module 4.1: Behaviour change communication – HIV transmission

Session objectives	At the end of the training session, trainees will be able to:
	Illustrate the importance of considering the context in which risk behaviours occur
	Review the different transmission modes and window periods for different transmission risk situations
	Illustrate the use of the four principles of transmission
Time to complete sub module	1 hour 30 minutes
Training materials	PowerPoint presentation **(PPT08)**
	Cards to play the risk game (See session instructions below)
	Question box
	Evaluation form collection box
Content	The modes and principles of transmission
	Analysis of risk behaviour in context

Session instructions

1. Explain the four principles of HIV transmission and advise trainees to use the acronym ESSE — exit, survive, sufficient, and enter.
2. Engage the group in a discussion of how HIV is spread.
3. Discuss ways that HIV cannot be spread e.g. mosquito.
4. Distribute the risk cards. You can design your own or ask the group to write a broad range of risks. Include general social contact and daily living activities and situations.
5. Using the PowerPoint presentation **(PPT08),** display the slide on the four principles of transmission and discuss with the class.
6. Place four cards on the floor in the following arrangement:

7. Tell the class the following:
   - Each of you has a card (or maybe more than one). In a moment after my demonstration I will ask you to place the card next to the level of risk it holds for HIV transmission. You will be asked to explain according to the four principles why you have placed it where you have. You



will then be asked to discuss whether the card would have to be removed and placed elsewhere for other STD transmissions (e.g. hepatitis C, gonorrhoea, etc.). The group will then be asked what they think

8. Demonstrate to the group by using the "transmission-by mosquito card, going through each of the four principles. Emphasise that it is equally important to discuss why something is "no risk".
9. Conclude the activity by emphasising the following:
   - Risks vary with the context and manner in which behaviour occurs
   - This activity emphasises the importance of asking detailed information of clients when conducting a risk assessment
   - This activity clearly displays that detailed and explicit information is necessary to assist the client in understanding what is and isn't safe
10. Ask the group if they have any questions and remind them about the "question box".
11. Ask trainees to complete an evaluation form and place it in the "evaluation form collection box".

Suggested statements for the risk cards

[The answers in italics are to assist facilitators only – DO NOT include on the cards given to the trainees.]

- Blood splash to the eye during delivery
  Low risk – only one case in the world, which was concentrated virus in laboratory
- Cleaning up vomit
  *No to low risk for **HBV** (Hepatitis B Virus), **HCV** (Hepatitis C Virus) without gloves*
- Sharing spoons and forks
  No risk
- Using drugs prior to sex; using alcohol prior to sex
  Moderate to high risk — less likely to be safer sex
- Withdrawal (prior to ejaculation) — an option for safe sex?
  Low to moderate risk. Poor option for safer sex as couple may forget to withdraw, also virus present in pre-ejaculate, also risk for STI's
- Oral sex – man going inside the woman's mouth: risk to woman?
  Low to moderate for woman; no risk to man for HIV
- Vaginal sex – no condom, no ejaculation: risk to woman?
  Low to moderate risk. Poor option for safer sex as couple may forget to withdraw, also virus present in pre ejaculate, also risk for STI's
- Oral sex – with ejaculation (between men): risk to receptive man?
  Low to moderate
- Sharing injecting equipment (e.g. swabs, water, mixing bowls)
  Low for HIV; high for HBV and HBC
- Needle stick injury: "suture" needle
  Low – solid bore needle, often a sub-cutaneous injury
- Sharing syringe/needle
  High

- Vaginal sex – no condom, withdrawal, then ejaculation: risk to man?
  Moderate to high – poor option for safer sex as couple may forget to withdraw, also virus present in pre-ejaculate, also risk for STIs and parasites
- Penetrative anal intercourse – no condom, withdrawal, then ejaculation
  Moderate to high – poor option for safer sex as couple may forget to withdraw, also virus present in pre-ejaculate, also risk for STIs and parasites
- Vaginal sex – no condom, ejaculation: risk to woman?
  High
- Receptive anal intercourse – no condom, no ejaculation
  Moderate to high – poor option for safer sex as couple may forget to withdraw, also virus present in pre-ejaculate, also risk for STIs and parasites
- Needle stick injury: "venepuncture" needle
  Moderate level of risk dependent on factors such as depth of puncture, etc. Emphasise need to collect detailed information on exposure
- Sharing sex toys
  Low to moderate. More information required on type of sex toy and circumstance.
- Oral sex – with ejaculation (between men): risk to penetrating partner?
  No risk for HIV, avoid if the receptive person has oral herpes
- Oral sex – male to male, no ejaculation: risk to receptive man?
  No risk for HIV, possible STI parasite risk
- Oral sex – man going inside the woman's mouth: risk to man?
  No risk, possible risk for herpes lesions
- Deep kissing
  No risk for HIV
- Mosquito bite
  No risk
- Crying – getting someone's tears on you
  No risk
- Sharing toothbrush
  No risk
- "Rimming" – mouth contact with anus: risk to person performing?
  No risk
- Mutual masturbation: Risk to either?
  No to low risk depending on context and behaviour
- Sex during menstruation – with a condom, without a condom.
  With condom, low; without, high.
- Tattooing
  Requires further information on method and context of tattooing – could be low, moderate or high for ritual "group" tattoo

Module 2

Sub module 4.2: Behaviour change communication – Models of behaviour change

Session objectives	At the end of the training session, trainees will be able to:
	Demonstrate knowledge of models of behaviour change and issues relating to the efficacy of different models
	Demonstrate an understanding of the principles of behaviour change communication with regard to condom use and safe injecting
Time to complete sub module	2 hours
Training materials	PowerPoint presentation **(PPT09)**
	Penis/vagina models
	Condoms (2 per trainee)
	Syringes, 2 containers, water, food colouring and bleach
	Handout **(HO8)**
	Question box
	Evaluation form collection box
Content	Models of behaviour change communication
	The process of behaviour change, and the maintenance of behaviour change
	Condom and safe injecting demonstrations

Session instructions

1. Lecture with PowerPoint presentation **(PPT09).** During the presentation, ask the trainees questions to keep them involved actively in the presentation, *e.g. ask participants to brainstorm examples of the different behaviour change models as indicated in the presentation.*
2. Activity: *Condom demonstration and safe sex*. Allow at least 30 minutes for this activity.
   - Discuss and demonstrate the use of male condoms
   - Discuss each step and demonstrate while trainees read out each step
   - Ask the trainees to pair up and give each one a male penis model or banana or cucumber. Ask them to apply the male condom and receive feedback from their colleague

- Then switch off the lights and ask trainees to apply the condom in the dark and discuss this experience. Relate to the problems that clients have in applying condoms in real life
- Discuss negotiating skills and acknowledge the power imbalances between males and females
- Explore the advantages of using condoms
- Discuss the difficulties of practising safe sex in longer-term relationships
- Discuss the need to support clients in the removal of "truth barriers" in relationships. Ask the group to suggest examples of statements that we may make to partners in relationships that may prevent them from telling us that they have possibly been exposed to HIV and the need to use condoms and/or take a test. Note that some of these "barriers" may not be direct. We often infer how our partners will react to situations by the way they react to things they see in the relationships of families and friends. It is important that in this section of the programme you talk about negotiations with regular partners and disclosure

3. Activity: *Safe injection*.
   - Demonstrate how much "blood" may be left in a syringe after flushing only once
   - Then demonstrate flushing twice with cold water, twice with bleach (counting to 30) and twice with water
   - Draw trainees' attention to the handout **(HO8)** in the sections describing "Needle and syringe cleaning"
4. Ask the group if they have any questions and remind them about the "question box".
5. Ask trainees to complete an evaluation form and place it in the "evaluation form collection box".

Module 2

Sub module 4.2: Behaviour change communication – Models of behaviour change

Session objectives

At the end of the training session, trainees will be able to:

Demonstrate knowledge of models of behaviour change and issues relating to the efficacy of different models
Demonstrate an understanding of the principles of behaviour change communication with regard to condom use and safe injecting

1. "What happens when an individual begins to consistently engage in unhealthy behaviour?"

An unhealthy behaviour must be unlearned and the individual needs to:

- Identify the behaviour as harmful
- Understand what alternatives are available to them
- Be able to act on that knowledge
- Receive the support necessary to maintain the behaviour change

For example, an individual with heart disease needs to know what foods are contributing to the problem; how to replace them with better foods; how to prepare or acquire those foods; and, how to consistently eat them and not revert to their old eating habits.

Supporting behaviour change is a complex interaction between the provider and the client, which requires a great deal of insight into human nature and human motivation.

The challenge as counsellors is to acknowledge the difficulty of changing one's behaviour while establishing a relationship with the client that will help to support the behaviour change.

2. Behaviour change models and HIV [i]

No model of behaviour change incorporates all of the possibilities of human behaviour into its design. The three models presented here can be thought of as a tool in the assessment of the client and the concerns that the client presents.

2.1. The risk elimination model: "Abstinence is Best"

This model uses abstinence as a means of eliminating any possible risk for HIV infection with the client no longer engaging in sex or no longer sharing needles. The risk of infection is eliminated because the behaviour is eliminated. An example of a prevention education message directed at young people: "Just say no" and eliminate the problem.

[i] This material has been adapted with permission from the field tested materials provided by USAID/PSI New Start Counselling, Zimbabwe.

Pros and cons

- Some individuals need the ultimatum and the structure that this model provides as a *starting* point to getting back on track. Many detoxification centres for drugs/alcohol follow this model by getting the client off drugs – even for a few days – as this may provide a window of opportunity to begin a dialogue with the client about their behaviour
- While this model guarantees 100% safety from infection, it is very often the least useful of the behaviour change models. Most people find it extremely difficult to suddenly quit certain behaviour. Secondly, this model does not acknowledge that individuals find pleasure in engaging in certain behaviours. This model does not allow for alternatives, and turns a blind eye to human behaviour[ii]

2.2. The risk reduction model: "Use a Condom"

This model acknowledges that individuals do engage in sex and use substances such as intravenous drugs. Assuming that abstinence is not a viable alternative, the risk reduction model advises individuals to engage in "safer" sexual acts by using condoms whenever they have sex, or by not sharing their needles if they are going to inject substances.

Pros and cons

- On the positive side, this model acknowledges that no matter what we think, individuals will continue to engage in risky behaviours. Therefore, it may be better to find a way for them to engage in behaviours safely than to spend our energy encouraging the client not to engage in these behaviours at all
- However, this model cannot provide 100% guarantee that individuals will remain uninfected. For example, the client can still be at risk for possible HIV infection if the condom tears while having intercourse. Focusing so much of the message on *how* to use a condom does not allow for any discussion with the client about *why* they are engaging in the behaviours that put them at risk. Many counsellors therefore believe that this model lacks a humanistic and individualistic approach necessary for behaviour change

2.3. The harm reduction model

Harm reduction challenges the *"all or nothing"* approach to behaviour change, characterised by the previous models. This model acknowledges that risk is a part of everyone's life and ranks an individual's risk/s for HIV infection among other life issues such as illness, unemployment, and drug use. *Harm reduction* is designed to acknowledge the meaning/s attached to those behaviours.[1]

In this model, change takes place over time and is incremental.
Any positive change is good and one step closer to healthy behaviour.

The counsellor works with the client to:

- Identify their risky behaviours
- Understand the reasons why the client continues to engage in them
- Develop strategies for identifying what the client can begin to do to move toward healthier behaviour

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[i] "It is recommended that countries consider broadening the goals and methods of drug treatment from an abstinence-only goal to encompass treatment and prevention strategies that are more accepting of interim goals." A recommendation of the Task Force on Drug Use and HIV Vulnerability, (2000),
Drug use and HIV vulnerability policy research study in Asia UNAIDS/UNODCCP, 6

Pros and cons

- An example of harm reduction is the needle exchange programme. A client's addiction is acknowledged as well as the fact that stopping addiction might not be an immediate goal, but a long-term one. The harm reduction model acknowledges the difficulty of stopping substance use or risky behaviour. It ***"reduces the harm"*** to the individual by, for example, making clean needles available, thus reducing the risk of HIV infection
- Some counsellors may feel an ethical dilemma because this model does not provide the client with protection from immediate infection, as other models do

Conclusion

All three models, plus many more, are available to the HIV/AIDS counsellor for use with the client. The models are interchangeable as well: some aspects of one model and some of another model may be appropriate at different times for the client. The important issue is for the HIV/AIDS counsellor to know these models, and to use them not as absolutes but as helpful tools in the interaction with the client. The counsellor should keep in mind that the different behaviour change models presented here could be adapted to their own style, and to the differing needs of their clients [iii]

3. The process of behaviour change

- Behaviour change is a process, and can be thought of as taking place in stages. Understanding these stages helps to strengthen the counselling process, and it is equally important to know that no behaviour change follows an absolutely predictable pattern [iv]
- A client can conceivably go through the stages of behaviour change many times before a successful change can be achieved. These stages are a tool for the counsellor to apply when assessing the client and determining what stage of behaviour change the client is in

The different behaviour change stages according to the Centres for Disease Control HIV Prevention and Counselling Guidelines of 1993 are:[2]

1. Knowledge/awareness
2. Significance to self
3. Cost/benefit analysis
4. Capacity building
5. Provisional try
6. Behaviour change

Knowledge/awareness

It is important for the counsellor to assess the clients' knowledge and awareness regarding the risk of their behaviour. A client must know that they are at risk before a behaviour change can occur. Open-ended questions can be used for this assessment.

Significance to self

This is the ability of the client to connect the information that s/he has to his/her own behaviour. Many times clients will know how HIV infection occurs, but not be able to see how they are placing themselves at risk for HIV infection.

[ii] Nutbeam and Harris (1998) Theory in a Nutshell, University of Sydney, provides a concise and accessible summary of commonly used theories and models in health promotion applicable to HIV/AIDS related counselling. http://www.achp.health.usyd.edu.au/.

[iv] Benton and Paraell facilitating sustainable behaviour change, Burnet Centre (1999) provides an excellent introduction to the behaviour change spiral. Can be downloaded from http://www.burnet.edu.au

A client can respond to his or her own risk for HIV infection in any of the following ways:
- Recognising that their behaviour places them at risk for HIV infection
- Be unwilling or unable to accept that their behaviour could result in HIV infection
- Recognising the risk and feeling helpless, hopeless, and unable to their change behaviour

Counsellors can assist clients in recognising that their behaviour can place them at risk for HIV infection.

Risk/benefit analysis

The risk/benefit analysis acknowledges that there are both gains and losses for the client in creating a behaviour change. Risk/benefit analysis looks at the pros and cons of both the current behaviour and the desired change, and assists the client in expressing the losses they might feel in giving up the old behaviour.

4. Capacity building

Capacity building is the preparation for behaviour change, including gaining the practical skills and other forms of support to manage the risks/costs of behaviour change. The counselling strategies during the stage of capacity building include:
- Providing clients with specific, practical and achievable skills
- Doing reverse role-plays and affirmations

Counsellors should not only give a condom demonstration but also find out the reasons that prevent the client from using condoms.

5. Provisional try

The provisional try is when the client leaves the counselling session and tries to implement a step toward changing behaviour. The counselling strategies during the stage of provisional try include:
- Planning for obstacles that clients may face
- Reframing "failure" with clients — counsellors must keep in mind that the behaviour change model allows for endless opportunities for failure

Even though provisional tries may not always be successful, the minimal attempt at behaviour change can be considered a success and must be supported by counsellors.

6. Maintaining behaviour change

- Maintenance of safer sexual behaviours over time depends on interventions that are continuous and repetitive in nature
- It is expected that some behaviour will change as an individual's life changes. For example, condom use may no longer be necessary when an uninfected person enters a monogamous relationship with another person who is HIV negative
- However, other changes — or relapses to less safe behaviour — may invalidate the previous safe behaviour and lead to HIV infection
- Rates of high risk behaviour and new infections will increase if interventions are withdrawn, therefore continued risk reduction depends on continued behaviour change programmes and continued encouragement and support from counsellors[v]

[v] Further reading: Prochaska JO, DiClimente CC (1984) The theoretical approach: Crossing boundaries of therapy. Homewood Ill, Dow Jones Irwin http://www.cdc.gov/hiv/pubs/guidelines.htm#counseling

7. Essential elements of behaviour change counselling

7.1. Assessment of risk and vulnerability

Clients need to assess personal risk for HIV infection and the various obstacles that may inhibit the use of condoms or safe injecting.

7.2. Briefing on condoms, condom use and safe injecting

Prevention/condom use messages must be crafted to motivate and appeal to the needs, beliefs, concerns and readiness of the specific client.

7.3. Skills in condom use and safe injecting

The practice of injecting correctly should be examined and strengthened. Critical thinking, decision-making and communication skills should also be strengthened in order to see the benefits of condom use and safe injecting and to be able to negotiate for their use.

7.4. Making a plan

The client should start to make a plan for condom use or safe injecting and the maintenance of these practices over time in pre-test counselling.

7.5. Supplies and resources

The counsellor should be able to suggest sources of reduced cost, high quality condoms, steps to safe injecting practice and, where possible, sources of necessary supplies to support safe injecting.

7.6. Reinforcement and commitment

The counsellor should review the client's plan for condom use or safe injecting in post-test counselling and any subsequent visits to the clinic.

7.7. Supportive environment

A supportive environment needs to be created to support condom use and safe injecting, including choices in condom use (male and female condom), supplies for safe injecting, the provision of print materials, and referral to hotline counselling services.

8. Helping clients become aware of their risks

8.1. Assessment of personal risk and vulnerability

Clients need to assess personal risk for HIV infection and the various obstacles that may inhibit the use of condoms or safe injecting.

Risk

- The level at which an individual or population engages in activities which place them at risk of HIV:
  - vaginal intercourse with or without STI
  - anal intercourse
  - needle sharing
  - transfusion of unscreened blood

Vulnerability

- Factors which reduce the ability to act, and increase vulnerability, e.g.:
  - economic pressure on families
  - lack of AIDS information for youth

- lack of skills to make rational decisions or to carry them out
- inability to access health services and commodities
- inability to assert rights

8.2. Briefing on condoms, condom use and safe injecting condom use

Prevention/ condom use/safe injecting messages must be designed to motivate and appeal to the needs, beliefs, concerns and readiness of the specific client.

Among barrier contraceptives, the male latex condom offers the best protection against STIs, including HIV/AIDS. When used consistently, male condoms also provide highly effective contraception.

The female condom also protects against STIs, including HIV/AIDS. Vaginal barrier methods such as the diaphragm, cervical cap, sponge and spermicides are less effective, even when these barriers are used with a spermicide.

The major public health challenge in reducing HIV/AIDS and other STIs is to encourage greater use of condoms among people at risk. Women and men report not using male condoms for many reasons, including fear of partners' reactions, partner opposition, lack of confidence in the product, lack of access to condoms or decreased pleasure if used.[vi] In addition, family planning providers often encourage clients to consider the more effective contraceptives, such as injectables, and discourage reliance on the condom as a means of preventing pregnancy.

Despite the fact that the condom is very effective against STIs, many people at risk do not use them. Some bacterial STIs, such as gonorrhoea and chlamydial infection, are easily transmitted, making consistent condom use especially important. Promoting condoms among men and youth, and encouraging better attitudes about condom provision among family planning providers and other health professions may help reduce the number of new infections.

People tend to avoid condom use if they believe their partner is "safe". Using behaviour as a surrogate for STI risk may be particularly problematic when studying persons who might vary their use of condoms with partners of "varying risk," for example, sex workers' perceptions of risk with regular clients, non-regular clients, and live-in partners.

Gender issues

Addressing gender issues may be as important as focusing on increased condom use. Consistent, sustained use of condoms requires behavioural change. Men's sexual behaviour is linked to their sense of masculinity. In many cultures, assumptions about masculinity may encourage excessive alcohol use or violent behaviour towards women, which can increase risky sexual behaviour. Women may also be at a disadvantage in requesting and negotiating the use of condoms with their partners.

Young people

Encouraging young people to use condoms and to develop skills to refuse unwanted sex is also crucial. Globally, HIV infections are rising fastest among those under age 25, especially women. Youth are often inexperienced with condoms, feel invulnerable to risk, have spontaneous sex and are

[vi] See also CDC, Revised guidelines for counselling, testing and referral 1999 http://www.cdc.gov/hiv/pubs/guidelines.htm#counselling

embarrassed to interrupt sex to put on a condom. Some young women need skills to refuse risky *sex* from male partners, especially older men.

Young men and women tend to think more about pregnancy prevention rather than STI prevention. Messages should be adjusted to focus on the dual protection qualities of condoms.

Accessibility of condoms
Family planning programmes, clinics and pharmacies in some countries are often unwilling to distribute condoms to unmarried youth. Accessibility to condoms may also be difficult for youth due to cost, stigma, embarrassment and other barriers. Youth are more likely to use condoms that are more readily available at shops, grocery stores and in vending machines.

Many men and women are reluctant to use condoms due to reported loss of sensation and pleasure caused by the condoms. However, men and women may find some of the newer condoms more pleasurable to use, thereby encouraging condom use. Unlike latex condoms, polyurethane male condoms, for example, facilitate body heat transfer, which may increase pleasure. Some products are designed to be easier to put on than traditional latex condoms. Synthetic non-latex condoms will not cause allergic reaction. Proper use of these lubricants will also increase pleasure while reducing friction and risk of condom tear.

Safe injecting
Injection of any sort is an even more efficient way of spreading HIV than unprotected sexual intercourse. Since injecting drug users are often linked in tight networks and commonly share injecting equipment with other people without cleaning it, HIV can spread very rapidly in these populations.

Also, like other sexually active people, people who inject drugs may acquire HIV infection through their sexual partners if they have unprotected sex. A great deal of sexual transmission in some countries is a result of unprotected sex with an injecting drug user. In parts of China, India and Myanmar, more women are infected through sex with injecting drug users than any other way. Injecting drug use also contributes to mother-to-child transmission of HIV.

In relation to sexual transmission, the main means of risk reduction are similar to those that should be adopted by all sexually active people, namely, the consistent and proper use of condoms or the avoidance of penetrative sex.

In relation to transmission through sharing needles, syringes and other equipment, several methods of protection are available. Some of these offer better means of protection than others. In order of efficacy they include:[vii]

- Stopping injecting drug use
- Using sterile needles, syringes and other equipment every time
- Not sharing injecting equipment
- Cleaning equipment between use

[vii] "*A comprehensive package of interventions for HIV prevention among drug abusers could include:*
AIDS education, life skills training, condom distribution, voluntary and confidential counselling and HIV testing, access to clean needles and syringes, bleach materials, and referral to a variety of treatment options. This complete package should be implemented along with drug abuse prevention, especially among young people." Preventing HIV transmission among drug users, a position paper of the United Nations System (2000)

Without doubt, the most effective way of reducing the risk of HIV infection is to give up using drugs (risk elimination model) but where this is not possible, changing from injecting to non-injecting drug use can significantly reduce the risk of HIV transmission by non-sexual means. For those who inject opioid drugs such as heroin, this may be achieved through participation in a non-injectable drug substitution programme, in which a drug such as methadone is administered orally.

An important way of making clean syringes and needles more readily available is through needle and syringe exchange programmes. These programmes have several benefits when available. For injecting drug users, such programmes lower the proportion of contaminated needles in circulation, thus lowering the risk of new HIV infections more generally. They also reduce sharing and re-use occasions. These programmes have also been shown to be effective in preventing the transmission of HIV, and do not increase the use of illegal drugs. However, many governments and law enforcement agencies are reluctant to enact policies that will support such programmes. When exchange programmes are not available, the cleaning of injecting equipment between use may be the viable entry point for behaviour change related to safe injecting.

8.3. Skills in condom use and safe injecting

The client's level of technical skills to use a condom and practise safe injecting should be examined and strengthened.

Safe injecting

HIV can get into used needles, syringes, cookers, cottons and water. If injectors share any of these, they can become infected with HIV or pass the virus on to someone else. Bleach kills HIV. Injectors can clean their equipment with bleach and water.[3]

Injectors should be urged to always use new injecting equipment. However, where this is not possible, they should in the first instance use the preferred cleaning method known as the '2 by 2 by 2' method.

The best scenario is to always use sterile equipment for every injection. Anything short of this carries some risk of injection.

Needle and syringe cleaning

The '2 by 2 by 2' method

Injectors should be advised that all syringes that they think might be re-used should be cleaned immediately after first use. They should then be cleaned again before second use.

The best method for cleaning is to use the '2 by 2 by 2 method':

1. Draw COLD water (sterile or cool boiled is best) into the syringe and then flush it out down the sink or into a different cup. Do this twice.
2. Then slowly draw bleach (full strength 5.25% hypochlorite) into the syringe and shake it for as long as possible: 3-5 minutes are ideal, 30 seconds is the minimum. Flush it out down the sink or into a different cup. Do this twice.
3. Then draw COLD water into the syringe (as in step 1) and then flush it out down the sink or into a different cup. Do this twice as well.

Other cleaning methods

These methods may be ***less effective,*** but may actually be more readily adopted in certain contexts e.g. street use.

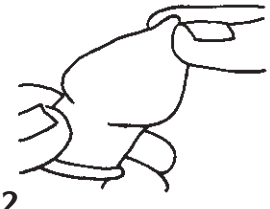
Male condom use

Proper male condom use

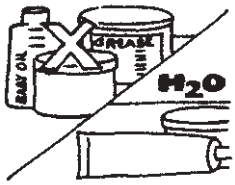
- It is advisable to decide on the use of a condom with your partner beforehand, as you may forget it in the heat of passion.
- Always check the expiration or manufacture date written on the condom package to make sure that the condom has not expired. Make sure the product is not more than four years old.
- Press the condom package with fingers to make sure it is intact.
- To open the package and identify the appropriate point to tear the package, push the condom downward, carefully tear the package with your fingers. Make sure your fingernails do not damage the condom. DO NOT use sharp objects such as scissors or razor as they may cut the condom.
- To put on the condom, the penis must be erect (hard).
- Ensure that the part to be unrolled is on the outside. Press and hold the tip of the condom with your thumb and forefinger to keep out the air.
- Place the tip of the condom on the head of the penis and using your other hand, unroll the condom all the way to the base of the penis.
- Keep the condom on during the intercourse. After ejaculation, while the penis is still in erection, pull out of your partner holding the condom at the base of the penis to prevent the condom from slipping off and spilling the semen.
- Wrap the condom in toilet paper and as soon as possible throw away the condoms somewhere out of reach of anyone else. Do not flush condoms down the toilet.
- NEVER reuse the condom.

How to use a male condom

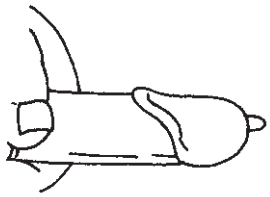
1
When penis is hard, squeeze air out of tip of the condom and place on head of penis.



2
Hold tip of condom and unroll completely.



3
Use only water-based lubricants on condoms, oil-based lubricants like Vaseline, Crisco, hand lotion or massage oil make condoms tear.



4
After coming (ejaculation), hold base of condom and pull out, Never reuse a condom.

If people are not going to go through the full '2 by 2 by 2' procedure, they should be advised to do anything/ everything they can to reduce the residue of blood in the syringe.

The chance of infection can be reduced if the injector cleans the needle and syringe by soaking the parts in either undiluted bleach or a strong detergent/water solution for as long as possible (at least several minutes), then rinsing thoroughly in water.

Female condom use

Proper female condom use (vaginal sex)

- It is advisable to decide on the use of a condom with your partner beforehand as you may forget it in the heat of passion.
- Always check the expiration or manufacture date written on the condom package to make sure that the condom has not expired. Make sure it is not more than four years old.
- Using your fingers, carefully open the condom package at the indicated place. Make sure your fingernails do not damage the condom. DO NOT use sharp objects, such as scissors or razors as they may cut the condom.
- Inspect the condom to make sure it is intact.
- Rub the outside of the condom to evenly spread the lubrication inside the condom. Add lubricant as desired.
- Find a comfortable position for inserting the condom.
- Hold the condom at its closed end. Squeeze the inner ring (the ring at the closed end of the condom) between the thumb and the middle finger with the forefinger between the two.
- Spread the vaginal lips with the other hand, and insert the condom in the vagina.
- Use your forefinger to push the inner ring all the way up in the vagina until you feel the pubic bone with your finger inside the vagina.
- Make sure the outer ring (at the open side of the condom) lies against the outer lips.
- Guide and insert the penis inside the condom. Make sure the penis does not go underneath or beside the condom.
- If during intercourse the penis does not move freely, there is noise, or the condom is going in and out with the penis, add lubricant (to the penis or inside the condom).
- If the outer ring is pushed in the vagina or the penis goes beneath or beside the condom, stop and put on a new condom.
- Keep the condom on during the intercourse. After ejaculation and after the penis is pulled out, squeeze and twist the outer ring to avoid that the condom spills semen and pull the condom out of the vagina.
- Wrap the condom in toilet paper and as soon as possible throw away the condom out of reach of others. Do not flush the condom down the toilet.
- NEVER reuse the condom.

How to use a Female Condom for Vaginal Sex

1

OPEN END (Outer Ring) covers the area around the opening of the vagina. INNER RING used for insertion. Helps hold the pouch in place.

2

HOW TO HOLD THE POUCH HOLD inner ring between thumb and middle finger. Put index finger on pouch between other two fingers.

3

HOW TO INSERT IT Squeeze the inner ring. Insert the pouch as far as possible into the vagina. Make sure inner ring is past the pubic bone.

4

MAKE SURE PLACEMENT IS CORRECT Pouch should not be twisted, Outer ring should be outside the vagina.

Injectors can also be advised that boiling needles and syringes for 15-20 minutes will also sterilise them (although boiling plastic syringes may lead to distortions of the plastic and leakage).

In particular, washing the needle and syringe several times (for example, 10 times) with cold water immediately after use — before the blood and drug solution have had a chance to dry — is likely to flush out most infectious agents.

Failing this, using water or even vodka, wine or beer to flush out the syringe and needle before reuse is likely to reduce the risk a little. People should be cautioned against using this method unless it is a last resort.

8.4. Making a plan

Safer sex and injecting

The client should start to make a plan for condom use or safe injecting and the maintenance of these practices over time in pre-test counselling. Critical thinking, decision-making and communication skills should also be reinforced in order to see the benefits of condom use and safe injecting and to be able to negotiate for their use.

Negotiating safe sex and condom use

When should you start talking about condoms? When should you pull one out and what word will you use? How will you urge your partner to use one? How will you answer these questions and those of your partner? Say repeatedly, “I want us to use condoms every time we have sex.” Speak clearly with resonance. Start to have the feeling that it is natural to say these words. Give them rhythm. Say them in a soft romantic voice. Say them to protect your rights. Think whether you will be the one to put on the condom or will your partner put it on. In reality there are many people who do not consider using condoms to be important. They can find too many reasons or make excuses not to use them. If you make excuses, it means that you do not love yourself or your partner enough.

Some people say that they always use condoms. But when they go out with their friends, they may end up having sex with their friends or someone who has caught their eye, male or female. Condoms are not used because they trust their friends, trust each other, or they do not have one when needed. Other people say that they sometimes use condoms and sometimes they don’t. If their partner is good looking, dresses well, they believe that their partner cannot have HIV. But this is not the case. How a person looks is no indication of whether they have HIV or not! Still others say that sometimes they allow their partners to perform anal or vaginal sex and they are not sure whether condoms are used. It is not until they are finished that they know if a condom was used or not. Or, they make excuses: they were drunk, forgot, were not quick enough and condoms are difficult to use or unnatural.

One of the problems with discussing condom use with young women, for example, is that lots of girls feel like admitting to using condoms is an indication that they sleep around. But in reality this sign of confidence and responsible behaviour is likely to be more appealing to a man than sleeping with a girl and finding out later he has an STI.

Why do people use drugs?

People may use drugs at particular times in their lives: when they are young and experimenting or old when they need relief for pain. They also use drugs in different ways at different times. Many theories exist about why people use drugs but there is no simple answer. Drug use and drug problems appear to be influenced by a range of factors, so no single theory seems adequate. It is important to remember that there are both legal and illegal drugs and that legal drugs may be as harmful as illegal drugs.

Users of illegal drugs are often poor; criminalised; stigmatised; discriminated against and jobless /work on odd jobs to support their habit. They beg, borrow or steal to get the next fix. Many are homeless/ live on the streets. They have low self-esteem; low concern for personal health; and low trust level.

Safe injecting

There are many reasons why injecting drug users share needles and syringes and why there is a lack of clean injecting equipment. Some realistic strategies to prevent sharing of injecting equipment include:

- Raising the level of awareness of risks associated with sharing among IDU clients
- Discussing with the client how they might access sterile injecting equipment (Counsellors can enquire and crosscheck whether this is something your centre or institution could assist in)
- Providing written information on safe injecting, including information on cleaning equipment
- Conducting outreach-counselling sessions to IDUs (perhaps education in small groups rather than just one-to-one counselling) [4]

8.5. Supplies and services

The counsellor should be able to suggest sources of reduced cost, high quality condoms, steps to safe injecting practice and, where possible, sources of necessary supplies to support safe injecting.

Services and supplies will depend on their availability in each location. The counsellors should compile a list of reliable services that may be distributed to the clients when needed.

8.6. Reinforcement and commitment

The counsellor should review the client's plan for condom use or safe injecting in post-test counselling and any subsequent visits to the clinic.

The counsellor should ask the client to summarise the pre- and post- test counselling sessions by asking them to review their choices to reduce their risk of HIV/STI infection. These should include the use of condoms and safe injecting. The client should then state the advantages and disadvantages of each choice and then explain which choice(s) are the most motivational and realistic for the client to implement.

Together, the client and the counsellor will re-examine any obstacles which may prevent behaviour change from taking place (e.g. access to supplies and services, lack of negotiation skills, etc.) and discuss how these obstacles may be overcome or additional support provided.

8.7. Follow up and support

A supportive environment needs to be created to support condom use and safe infecting, including choices in condom use (male and female condom), supplies for safe injecting, the provision of print materials, and referral to hotline counselling services.

Provision of print materials will depend on their availability in each country. When materials are distributed to the clients, the client's counsellor should summarise the contents of the materials. Referral to follow-up counselling and support services will also depend on the availability of services in each setting. All referrals should include names of services, addresses, contact numbers and, whenever possible, the names of contact persons in each service.

References

[1] Des Jarlais DC, Hagan H, Friedman SR (1998) Preventing epidemics of HIV-1 among injecting drug users, drug injecting and HIV infection, Stimson G, Des Jarlais DC, Ball A, eds, WHO 1998, 183 – 200
[2] Centre for Disease Control (CDC) (1993), Technical guidance on HIV counselling, http://www.cdc.gov/mmwr/preview/mmwrhtml/00020645.htm
[3] Centre for Harm Reduction and Asian Harm Reduction Network (1999) http://www.ahrn.net/manual.html. (Thai and Indonesian versions can be downloaded. English versions are available in hard copy)
[4] Ibid. 202

Module 2

Sub module 4.3: Behaviour change communication – Problem solving

Session objectives	At the end of the training session, trainees will be able to: Illustrate the importance of considering the context in which risk behaviour occurs Apply problem solving-skills to client risk situations
Time to complete sub module	1 hour 30 minutes
Training materials	PowerPoint presentation **(PPT10)** Activity sheets (case studies) **(AS12)** Handout **(HO9)** Question box Evaluation form collection box
Content	Contextual setting of risk behaviour Applied problem solving for behaviour change

Session instructions

1. Introduce the notion that *"clients may need assistance in resolving the problems they face in trying to practise safer sex or safer injecting. Whilst many clients are aware of what they need to do to protect themselves, they may not have the skills or be able to overcome the problems they face in implementing changes"*. Also note that in moderate to late stage HIV illness, the executive functioning of the brain can be altered, causing problems with organisation, planning and critical thinking. This in turn can make it difficult for individuals to resolve practical problems.
2. Lecture with PowerPoint presentation (**PPT10).**
3. Discuss the steps in collaborative problem solving.
   - Use a practical example and involve the class in a group brainstorming of options
   - Involve the class in critically evaluating the options and similarly involve them in developing an action plan
   - Keep the activity short as it is just provided to demonstrate each step of problem solving
4. Emphasise that clients learn skills in one context (e.g. safer sex) and can apply these to other situations (e.g. relationship problems).
5. Activity: *Case studies* **(AS12).**

- Divide the trainees into two groups and give them the cases to discuss for 20 minutes
- Ask trainees to consider each case using the *"Steps in problem solving"*
  - Describe the problems identified
  - Brainstorm on options available for the client
  - Critically evaluate the different options (anticipating the logical or expected consequences of following the different options)
  - Ask client to select one option
  - Develop a plan of action
  - Facilitate development of skills and strategies with the client

6. Ask for feedback from the group about the problem-solving activity. Look at the options that were raised and the strategies to be employed by the counsellor to assist the client.
7. Ask the group if they have any questions and remind them about the "question box".
8. Ask trainees to complete an evaluation form and place it in the "evaluation form collection box".

Case study 1

The client is a thirty two-year-old heterosexual technical officer working for a company. He has been working away from his home. He frequently travels for work. His wife has not seen him for two months as she has stayed home with her eighteen month-old son. She is two months pregnant.

He recently attended a clinic as he had a discharge from his penis and is diagnosed with an STI. He confesses that he has been visiting bar girls occasionally at music bars. The doctor provides him with medication for his STI.

He tells you that he is worried about returning home. He doesn't know what to do about his wife. He asks you whether taking medication will make his symptoms disappear. He is hoping he can avoid telling his wife. He also wants to know what he is to do if the infection persists. The counsellor raises the possibility of HIV infection. The client had not even thought of any HIV risk.

Case study 2

The client is a 23-year-old woman who is a part-time shop assistant. She lives in student a accommodation. She also works at a bar as a sex worker. She is worried about her current STI, though it has been successfully treated, as she usually does not practice safe sex. She doesn't want to spend money on condoms as her clients do not like her to use them. She is ashamed to talk about her work and her infection.

She is using some of her earnings to help support her family who live in a village and has a child as well to support. The family would disapprove of her work if they knew. But they are happy that she can support herself. She has little opportunity to engage in other work; especially work that pays enough to support her family. She gets paid more if she doesn't use condoms. She is often a little intoxicated with alcohol when she engages in sex work. She discloses that sometimes clients can get a little aggressive and rough.

She has recently met a man. He does not know about her sex work. They do not use condoms during sex. He is a respected member of the community, so she does not use condoms.

Module 2

Sub module 4.3: Behaviour change communication – Problem solving

Session objectives

At the end of the training session, trainees will be able to:

- Illustrate the importance of considering the context in which risk behaviour occurs
- Apply problem-solving skills to client risk situations

Problem solving can be easily learned and applied to a wide range of situations commonly encountered in VCT services. It can be used to assist clients resolve difficulties they encounter in reducing the risk of contracting or transmitting HIV, planning HIV status disclosure to partners, managing family or relationship issues, and resolving issues related to accessing care and treatment.

Problem solving has been successfully used in counselling for threatened loss (e.g. important relationship, job loss), actual loss, conflicts in which a person is faced with a major choice (e.g. whether or not to leave a situation or take on a new role), family and relationship conflicts, suicide attempts[1].

Illness affects problem solving capacity[2]

This is an important consideration where people are going in for HIV tests with mid to late – stage infection.

- Organisation, planning and critical thinking are often impaired during illness
- Mood can affect motivation and physical capacity to think
- Personal history, e.g. education and personality style, affect approach to problem solving, e.g. dependency

Broadly speaking, one can divide people who can be helped by problem solving into two categories:

1. Those clients who generally cope well but are not doing so at present, perhaps because of illness or the nature of the dilemma that they face, and
2. Those with poor coping resources.

Aims of problem solving[3]

The aims of problem solving are to assist clients to identify problems. Counsellors can:

- Help clients to recognise the resources they possess for approaching their difficulties
- Teach them a systemic method of overcoming or reducing the impact their current problems
- Enhance their sense of control over problems
- Equip them with a method for tackling problems

Problem solving is not

- Telling the client what their options are
- Telling what the good and bad points of the options are
- Choosing the option for the client
- Telling them what they must do
- Expecting the client to have the skills and confidence to put the plan into action

Taking responsibility for the client

- Results in dependency of the client
- Feelings of inadequacy in the client
- Projection of blame on the counsellor if desired outcome does not take place

The role of the counsellor[4]

The skills are not complicated and most people will require little more than encouragement and practice. Counsellors should work through the steps of problem solving with the client and should also assist the client in developing an action plan and developing the necessary skills to carry out the plan, e.g. negotiations skills, etc.

Steps in problem solving[5]

1. **Describe the problem**: The counsellor assists the client to define problems and set goals. Defining goals helps to focus thinking on the issue at hand and minimises the possibility of getting sidetracked onto other issues, e.g. is the problem how to negotiate with their partner to use condom; is the problem raising the issue of the need for an HIV test with a partner?

2. **Brainstorm options:** Brainstorming is a method by which clients come up with as many alternative solutions as possible. Rather than try to think of the best or ideal solution, the client should be encouraged to list as many ideas and potential options as possible. The counsellor can provide assistance by suggesting options when the client is unable to. There should be no coercion in the process.

   No options should be omitted at this stage. The aim is for the counsellor to encourage the client to consider all options, e.g. if we take the example of a newly diagnosed client raising the issue of a partner needing to have an HIV test, the options could include the client telling the partner themselves, a counsellor telling the partner, the client telling the partner in the presence of the counsellor, not telling the partner, etc.

3. **Critically evaluate self-talk about options**: This step involves a critical review of the client's "self talk" or beliefs about each of the options. The counsellor should facilitate a brief discussion of the advantages and disadvantages of each solution and challenge any of the client's beliefs about the options. It may be helpful if the counsellor records this information so that the client has a record of this process. e.g. using the example above about disclosing to a partner about the need for an HIV test. Only a limited range of options are explored here as this is just an example.

4. **Client chooses:** In this step the counsellor assists the client in reviewing the information obtained in the previous step and to make a decision. The client should make the decision, not the counsellor.

Options	Advantages	Anticipated problems	Counsellor challenge
Client telling partner alone	Client feels that the partner may respect honesty	Client fears partner will be abusive or aggressive	Counsellor asks, "Have you ever experienced your partner being abusive before? What do you believe contributes to your partner responding this way?"
Client telling partner in the presence of a health worker	Offers some protection for the client Counsellor could answer questions the partner raises	Client fears the partner may be angry as the discussion did not occur privately	Counsellor asks the client, "Has your partner ever indicated to you that he/she feels uncomfortable talking about personal problems in front of others? How does your partner feel about nurses and doctors?"

5. **Develop a plan of action:** A detailed plan of action will increase the likelihood of the problem being solved. Even if the agreed solution is excellent, the solution will not be of any use if it is not put into practice. The most common reason for failure is a lack of planning. The counsellor should ensure that the client is assisted in developing an action plan that is feasible.

6. **Facilitate the development of skills and strategies:** The counsellor should ensure the client has the necessary skills, e.g. communication skills. The counsellor may use "skills rehearsal" to improve the client's confidence in taking the necessary steps to achieve their goal. For example, the counsellor may engage the client in role-playing the disclosure and anticipate the partner responses and the client's subsequent response.

Be realistic!

Even good plans fail because of:

- Psychological/behavioural responses of others
- Circumstances that couldn't have been predicted

You are more likely to succeed if you have a plan.

If things do not work out, they generate more options and an opportunity to analyse why the original plan didn't work.

The application of problem-solving strategies to HIV prevention counselling

1. Explore constraints to HIV prevention.
2. Brainstorm options.
3. Review the logical consequences of each option.
4. Develop a plan of action.
5. Rehearse skills such as disclosure with the client.
6. Offer "action" support.

References

[1] Hawton, K and Kirk, J. in Cognitive behaviour therapy for psychiatric problems: A practical guide, edited by Keith Hawton, Paul Slkovskis, Joan Kirk and David Clark (2000). Oxford Press. United Kingdom.
[2] Kalichman, S. (1995) Understanding AIDS: A guide for mental health. Professional American Psychological Association Washington USA
[3] Hawton, K and Kirk, J. in Cognitive behaviour therapy for psychiatric problems: A practical guide, edited by Keith Hawton, Paul Slkovskis, Joan Kirk and David Clark (2000). Oxford Press. United Kingdom.
[4] Nelson-Jones, R. (1990). Thinking skills: Managing and preventing personal problems. Royal Melbourne Institute of Technology. Melbourne.
[5] World Health Organization Collaborating Centre for Mental Health and Substance Use (1997) Management of Mental Disorders. Sydney Australia.

Module 2

Sub module 5.1: Overview of pre- and post-HIV test counselling

Session objectives	By the end of the training session, trainees will be: Provided with an orientation to the pre- and post- HIV test counselling modules
Time to complete sub module	15 minutes
Training materials	PowerPoint presentation **(PPT11)** Handout **(HO10)** Question box
Content	Orientation to the key components of the WHO model of pre- and post- HIV test counselling

Session instructions

1. Explain to the trainees that we will approach the teaching of the pre-test counselling module via a series of building blocks.
   - Note that we have already covered the "Rationale for VCT", "Basic HIV information", "Introduction to testing" and "Behaviour change communication" components of pre- and post- HIV test counselling
   - Indicate that we will now progress to building further skills and then integrate all of these skills into a comprehensive package of pre- and post- HIV test counselling
2. Present the PowerPoint presentation **(PPT11)** and demonstrate that we will be covering all aspects of the pre- and post- HIV test counselling.
4. Ask the group if they have any questions and remind them about the "question box".

Module 2

Sub module 5.1: Overview of pre- and post-HIV test counselling

Session objectives

To provide trainees with an orientation to the pre- and post-HIV test counselling modules

Figure 3: **Learning to conduct pre- and post-HIV test counselling demands a skills-building approach**

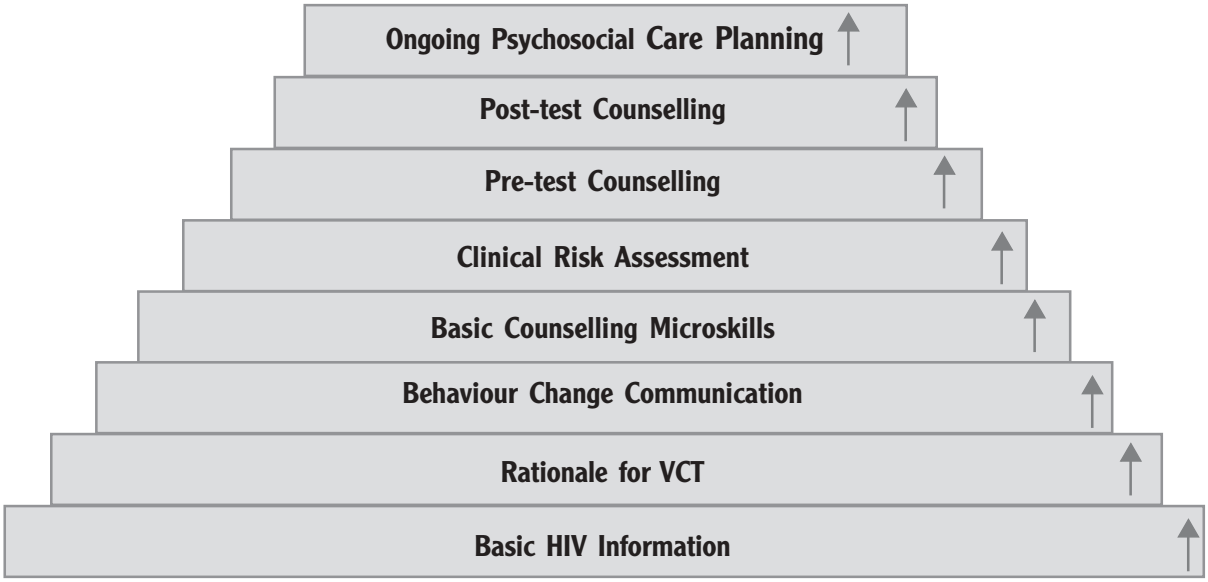
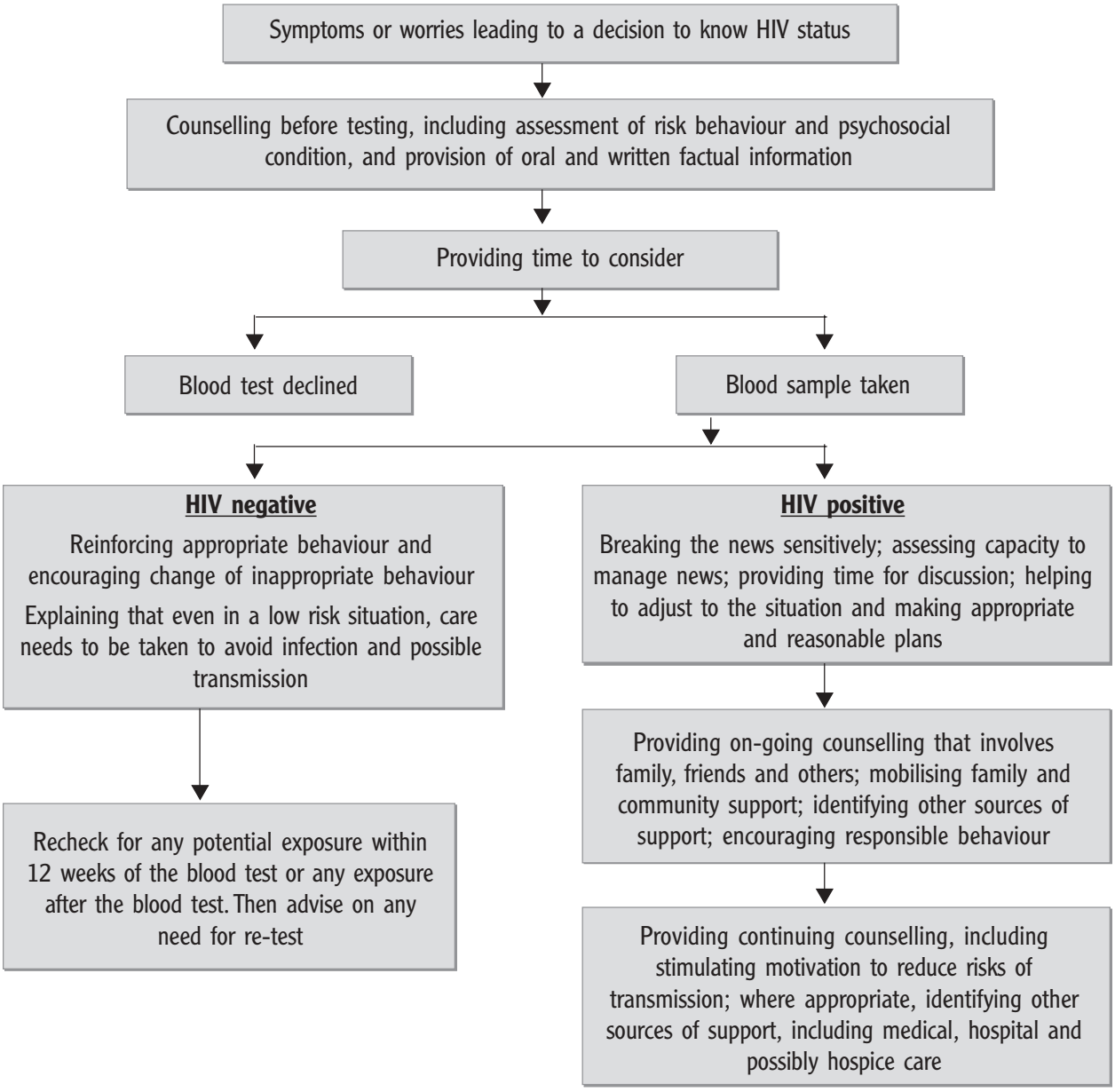


Figure 2: **The "Gold Standard Model":**
Pre-test and post-test counselling in relation to HIV-infection[1]



This model outlines the key procedures involved in providing VCT **(Fig. 2)**. However, the model should be adapted to meet the needs of your service. In some services, couples are seen together and in others, where there is high volume client flow through services, group information provision can be combined with more limited "one-to-one" pre-test counselling to reduce the time of one-to-one counselling.

These approaches to client service delivery will be discussed in Module 5, sub module 2: Models of VCT service delivery.

Reference

[1] WHO (1994), Global Programme on AIDS

Module 2

Sub module 5.2: Clinical risk assessment

Session objectives

At the end of the training session, trainees will be able to:

- Conduct a clinical risk assessment and provide feedback on the level of risk
- Manage discussing sensitive issues
- Assess risks within the HIV test window period

Time to complete sub module

2 hours 15 minutes

Training materials

- PowerPoint presentation **(PPT12)**
- Overhead transparencies of the 'individual risk assessment activity worksheet' as later attached in this session plan (several copies required)
- Non-permanent markers, overhead projector and screen
- Activity sheets
  - **AS13a –** risk assessment worksheets for counsellors
  - **AS13b –** case studies for clients
- Handout **(HO11)**
- Question box
- Evaluation form collection box

Content

- Clinical risk assessment
- Assessing and providing feedback on the level of risk
- Assessment for referral
- Window period
- Assessment of coping
- Discussing sensitive issues
- Clinical risk assessment – role-plays

Session instructions

1. Ask trainees what are the clinical and public health reasons for conducting a detailed risk assessment. Key answers you may need to prompt them on are:
   - So that other health conditions may be screened for identification and treatment, e.g. STIs, TB, HBV, parasites
   - Presents an opportunity to educate the clients about risks in a detailed manner
   - Enables the health worker to more adequately provide feedback on risks
   - Assists the counsellor to identify whether the client will need to re-test to cover significant window period exposures and engage in risk reduction whilst in the window period
2. Ask trainees what type of difficulties counsellors or clients could experience during a clinical risk assessment.
3. Lecture with PowerPoint presentation **(PPT12)**. Individual risk assessment may be modified where cultural or client safety issues do not permit such an explicit sexual history. Remind them that if a detailed history is not done then a thorough STI screening will need to be conducted.
4. *Activity*: Risk assessment.
   - Explain that we are going to conduct a detailed and sensitive assessment that may be difficult
   - Divide trainees into pairs and ask them to act as a counsellor and client, then switch roles after the first case
     - For the counsellors, give them a copy of **AS13a** (the risk assessment worksheets) and ask them to complete the worksheet based on the case discussed with them by the client
     - For the clients, give them a copy of **AS13b** (the case studies). Instruct that only the person role-playing the client should get a case **(AS13b)** and that this should not be shown to the counsellor
   - Prior to the commencement of the activity, review how the trainees could explain and explore the various risks on the risk assessment form. They should consider why the client has presented for a test and where to start on the risk assessment with the client, e.g. for a married woman presenting for screening, risk assessment should commence with vaginal sex; for drug users it should start with needle sharing and move to sexual; for men who have sex with men, the assessment should start with either oral or anal sex and then proceed to enquire about vaginal
     - Remind the trainees who are role-playing as counsellors to “educate” about a risk first and then enquire if that particular exposure risk is a risk for them. Remind them not to ask a series of invasive questions
     - Remind participants to note the date of exposure for each risk. This will aid them in distinguishing different window periods for different infections such as HIV, HBV and STIs
   - Commence the activity and then switch roles after the first case
5. Debrief the trainees on the risk assessment activity.
   - Use the trainer’s overhead transparencies with the ‘individual risk assessment activity worksheet’ (on page 110)
   - Place the transparencies on the overhead projector and ask participants to read all the cases.
   - Complete the transparency form in front of the class by asking the trainees the relevant questions, e.g. “Did this client share needles? When did this last occur? Is this in the window period? When should the next test occur?”
   - Work through all of the cases
   - If a trainee offers an incorrect answer, ask the group if they agree with it?
   - Mark the responses on the transparency
   - After recording the answers for the case on the overhead transparency, rub out the answers and start again with the next case or use a new transparency

6. Congratulate the group on their work. Remind participants to read the handout.
7. Ask the group if they have any questions and remind them about the “question box”.
8. Ask trainees to complete an evaluation form and place it in the “evaluation form collection box”.

Risk assessment activity instructions

(these are also included in **AS13** and **H011**)

- Introduce yourself and explain your role to the client
- Explain the difference between HIV and AIDS
- Explain the window period. You could try using the script below:

Window Period

When HIV infects a person’s body, their body realises HIV is a virus that should not be in the body.

The immune system in the body begins to develop antibodies to try to kill the HIV and protect the person. The test used to check for HIV looks for these antibodies in the blood, and is called an antibody test.

It can take up to 12 weeks after infection with HIV for these antibodies to develop.

This means that an HIV test cannot guarantee a person’s HIV status as negative if they have had any risk for HIV in the 12 weeks immediately before the test. This time period of 12 weeks before the test is called the ‘window period’.

- Briefly explain the general modes of transmission – unprotected sex, mother-to-child, sharing injecting syringes and infected blood products
- Then explain that you need to discuss some things that may be very sensitive and private – offer the explanation in the box

I need to discuss some things today that perhaps normally we wouldn’t discuss with others. I need to discuss these things in order to be able to:

1. Give you realistic feedback about your risk of being infected – you may be worrying unnecessarily.
2. To make sure you know how to keep yourself and your partner/s safe in future – different practices have different risks.
3. To see if you have other potential health problems that this test will not identify – maybe I will need to do other types of tests.
4. If you have been infected, it is important to know when you most likely became infected – it may make a difference to the type of treatment we offer. We can only know this if we know what you have been doing and when.

As you can see these are some good reasons for us to talk openly about these things even though it may not be comfortable.

- Start the questionnaire by asking why the client is testing and whether the client has had the test before. Then ask if they had sex with women, men or both
- Then choose an appropriate place to commence moving from the less sensitive areas to the more sensitive. Educate first, then ask if the client feels the risk applies to him/her
- Complete the "counsellor only" section of the form. Make sure you note whether the client is in the window period or not and whether s/he requires retesting and when

Individual risk assessment activity worksheet

(trainers should make several overhead transparencies for large group feedback)

	Client code:		
Client has regular partner:	YES/NO		
Regular partner's status:	HIV positive /Unknown /HIV negative		
Date of last test:_____			
Client/partner[1] indicates history of STI infection:	YES/NO		
Treatment referral required:	YES/NO		
Client/partner[2] reports symptoms of TB:	YES/NO		
Treatment referral required:	YES/NO		
Occupational exposure:	YES/NO	Date :	Window period: YES/NO
Tattoo, scarification:	YES/NO	Date :	Window period: YES/NO
Blood products:	YES/NO	Date:	Window period: YES/NO
Vaginal intercourse:	YES/NO	Date :	Window period: YES/NO
Oral sex:	YES/NO	Date :	Window period: YES/NO
Anal intercourse:	YES/NO	Date :	Window period: YES/NO
Sharing injecting equipment:	YES/NO	Date :	Window period: YES/NO
Client risk was with a known HIV positive person:	YES/NO		
Client is pregnant:	YES/NO		
Stage of pregnancy:	1st trimester/2nd trimester/3rd trimester		
Client/partner[3] is using contraception regularly:	YES/NO		
Client requires repeat HIV test due to window period exposure: YES/NO			
Date for repeat re-test:			

[1] Circle either or both client/partner
[2] Circle either or both client /partner
[3] Circle either or both client /partner

Case study 1

This is a case of a male, 35-years-old. He is married and has two young children aged four and two. He has decided to have an HIV test on the suggestion of his doctor. This suggestion followed the recent diagnosis of gonorrhoea, a sexually transmitted infection, on his last visit to the doctor.

He reluctantly reports that he often has anal sex with other men, the most recent occasion being three weeks ago. He reports that this usually occurs when he has been drinking alcohol and that he does not use condoms. His wife is unaware of his sexual practices. He does not use condoms with his wife. He reports the most recent occasion of vaginal sex with his wife was two weeks ago.

He is unsure what he would do if he tested HIV positive. He is particularly concerned with how he would tell his wife and how she may react.

Case study 2

This is a case of a female, 28-years-old and married. Last week a doctor confirmed she was six weeks pregnant. When she told her husband about the pregnancy, he told her that he was HIV positive. For this reason she has decided to have an HIV test. She is very upset with her current situation. She is angry with her husband and worried for herself and her unborn child. Her husband has told her that he has visited commercial sex workers. She reports she most recently had unprotected vaginal sex with her husband two weeks ago.

Case study 3

This is a case of a male, 21-years-old. He states he has heard about HIV from some of his friends and has started to worry about whether he may be infected. He reports having had unprotected vaginal sex with several different female partners. The most recent occasion was one week ago.

Discussion also reveals that he has experimented with injecting drugs. He reports that the needles he used were shared and not cleaned between use. He most recently experimented with drugs four months ago.

Case study 4

This is a case of a male, 26-years-old. He states he has tested previously for HIV. His most recent test was two years ago and was HIV negative.

He identifies himself as homosexual and states that all his sexual partners have been male since he was about 20-years-old. He expects that his result will be HIV negative and states that he is testing “just to be sure”. He reports that he usually practices safer sex and makes sure that he or his partner always withdraws when ejaculating if condoms are not used. He most recently used withdrawal without condoms three weeks ago. During discussion he recalls two occasions where condoms have broken during sex. These occasions were both more than 12 weeks ago.

Module 2

Sub module 5.2: Clinical risk assessment

Session objectives

At the end of the training session, trainees will be able to:

- Conduct a clinical risk assessment and provide feedback on level of risk
- Manage discussing sensitive issues
- Assess risks within the HIV test window period

Introduction

A major component of HIV pre-test counselling is the completion of a risk assessment.[1] It is important that the counsellor assesses the actual level of risk of the client as opposed to the client's perception of risk.[2] In order to fulfill this task, a risk assessment requires the counsellor to ask explicit questions about an individual's practices including:

- Sexual practices
- Drug using practices
- Occupational practices
- Receipt of blood products, organs or donor semen

Why conduct a detailed clinical risk assessment?

A detailed clinical risk assessment can:

- **Promote greater awareness and concern about STIs and HIV:** Many clients will have the opportunity to derive new information about HIV transmission

- **Provide an opportunity to extend prevention counselling and education:** Many clients will require education and assistance with problem-solving risk-reduction issues. Different behaviours have variable risk for HIV transmission. Providing clients with information on the level of risk associated with different risk behaviours can assist them in choosing to engage in lower risk activities

- **Determination of necessary health investigations:** Clients at risk of HIV may also require investigations for STIs, viral hepatitis, TB and other illnesses. An HIV blood test cannot provide a diagnosis for other conditions. Counsellors can assist clients by referring them to appropriate centres

- **Feedback for the client regarding levels of risk associated with various practices they may have engaged in:** Clients either "minimise" or "exaggerate" their risks. In order to prepare the clients to accept either a positive or negative test result, counsellors must provide realistic feedback on risk

- **Implications for treatment:** A detailed risk assessment can assist the physician in determining a post-diagnosis treatment strategy. Clients who are thought to have had a recent seroconversion to HIV will require different medical management than those who are diagnosed with late stage disease. The client may require additional treatments for other co-existing conditions such as STIs or TB. Other referrals such as to family planning services may be required based on information provided during the risk history period

Guidelines to taking history

Taking a risk assessment can be a culturally sensitive and difficult issue. It may engender embarrassment for the individual client or indeed for the counsellor himself or herself.[3] Counsellors are advised to acknowledge to the client that they may need to address some sensitive issues. It is suggested that counsellors use the following explanation:

> I need to discuss some things today that perhaps normally we wouldn't discuss with others. I need to discuss these things in order to be able to:
> 1. Give you realistic feedback about your risk of being infected – you may be worrying unnecessarily.
> 2. To make sure you know how to keep yourself and partner/s safe in future – different practices have different risks.
> 3. To see if you have other potential health problems that this test will not identify – maybe I will need to do other types of tests.
> 4. If you have been infected it is important to know when you most likely became infected – it may make a difference to the type of treatment we offer. We can only know this if we know what you have been doing and when.
>
> *As you can see, these are some good reasons for us to talk openly about these things even though it may not be comfortable.*

Counsellors should be aware of the following when conducting a risk assessment:

- Provide a private consultation area
- Assure the client confidentiality
- See each individual separately – do not take a history with another person present unless consent has been sought and given
- Assume the client will be embarrassed
- Ensure that the client understands the terms used
- Use clear and simple language
- Use models or drawings if needed
- Use neutral language – not colloquial or offensive terms
- Begin with less confronting issues to put the client at ease
- Obtain detailed information
- Discuss all practices with all people
- Remember your foundation skills in communication:
  - Listening
  - Questioning
  - Non-verbal skills or body language
- Do not allow your personal values or beliefs to enter the history-taking procedure

Instructions for the trainees to conduct clinical risk assessment activity

- Introduce yourself and explain your role to the client
- Explain the difference between HIV and AIDS
- Explain the window period. You could try using the script below:

Window Period

When HIV infects a person's body, their body realises that HIV is a virus that should not be in the body.

The immune system in the body begins to develop antibodies to try to kill the HIV and protect the person. The test used to check for HIV looks for these antibodies in the blood, and is called an antibody test.

It can take up to 12 weeks after infection with HIV for these antibodies to develop.

This means that an HIV test cannot guarantee a person's HIV status as negative if they have had any risk for HIV in the 12 weeks immediately before the test. This time period of 12 weeks before the test is called the 'window period'.

- Briefly explain the general modes of transmission – unprotected sex, mother-to-child, sharing injections and infected blood products
- Then explain that you need to discuss some things that may be very sensitive and private – offer the explanation in the box

I need to discuss some things today that perhaps normally we wouldn't discuss with others. I need to discuss these things in order to be able to:

1. Give you a realistic feedback about your risk of being infected – you may be worrying unnecessarily.
2. To make sure you know how to keep yourself and your partner/s safe in future – different practices have different risks.
3. To see if you have other potential health problems that this test will not identify – maybe I will need to do other types of tests.
4. If you have been infected, it is important to know when you most likely became infected – it may make a difference to the type of treatment we offer. We can only know this if we know what you have been doing and when.

As you can see, these are some good reasons for us to talk openly about these things even though it may not be comfortable.

- Start the questionnaire by asking why the client is testing and whether the client has had the test before. Then ask if they have sex with women, men or both
- Choose an appropriate place to commence moving from less sensitive to more sensitive issues. Educate first, then ask if the client feels the risk applies to him/her
- Make sure you note whether the client is in the window period or not and whether she/he requires re-testing and when

Individual risk assessment activity worksheet

	Client code:		
Client has regular partner:	YES/NO		
Regular partner's status:	HIV positive /Unknown /HIV negative		
Date of last test:_____			
Client/partner[i] indicates history of STI infection:	YES/NO		
Treatment referral required:	YES/NO		
Client/partner[ii] reports symptoms of TB:	YES/NO		
Treatment referral required:	YES/NO		
Occupational exposure:	YES/NO	Date :	Window period: YES/NO
Tattoo, scarification:	YES/NO	Date :	Window period: YES/NO
Blood products:	YES/NO	Date:	Window period: YES/NO
Unprotected vaginal intercourse:	YES/NO	Date :	Window period: YES/NO
Oral sex:	YES/NO	Date :	Window period: YES/NO
Unprotected anal intercourse:	YES/NO	Date :	Window period: YES/NO
Sharing injecting equipment:	YES/NO	Date :	Window period: YES/NO
Client risk was with a known HIV positive person:	YES/NO		
Client is pregnant:	YES/NO		
Stage of pregnancy:	1st trimester/2nd trimester/3rd trimester		
Client/partner[iii] is using contraception regularly	YES/NO		
Client requires repeat HIV test due to window period exposure:	YES/NO		
Date for repeat retest:			

[4] Circle either or both client/partner
[5] Circle either or both client /partner
[6] Circle either or both client /partner

References

[1] Ross, Michael, Channon-Little,L, Sexual health concerns: Interviewing and history taking for health practitioners. Second Edition McLennan and Petty Publishers Sydney
[2] Alana McCreaner in Counselling in HIV infection and AIDS John Green and Alana McCreaner (1996) Blackwell Science Publishers. United Kingdom
[3] Merrril, J.M.,Laux, L.F. and Thornby, J.L..(1990) Why doctors have difficulty with sex histories. South Medical Journal.

Module 2

Sub module 5.3: Pre-HIV test counselling

Session objectives

At the end of the training session, trainees will be able to:

- Apply knowledge of basic counselling microskills to the context of HIV pre-test counselling
- Integrate clinical risk assessment, HIV prevention education and counselling into HIV pre-test counselling
- Assess an individual's coping strategies and psychosocial support system
- Facilitate provision of informed consent by the client

Time to complete sub module

3 hours 30 minutes

Training materials

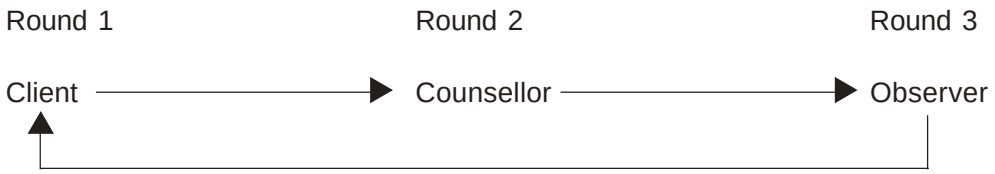
- PowerPoint presentation **(PPT13)**
- Activity sheet (case studies) **(AS14)**
- Handout **(HO12)**
- Question box
- Evaluation form collection box

Content

- Integrating basic counselling microskills into pre-HIV test counselling situation
- Incorporating HIV prevention education, risk reduction counselling into pre-HIV test counselling
- Assessing client's capacity to cope with a possible HIV positive result
- Assessing an individual's psychosocial support network
- Procedure for obtaining informed consent

Session instructions

1. Lecture with PowerPoint presentation **(PPT13).**
2. *Activity:* role-play.
   - Organise the class into triads (groups of threes). Each triad will comprise a "counsellor", a "client" and an "observer". Explain that all trainees will rotate between "counsellor", "client" and "observer" roles
   - There will be three rounds of cases. One case is to be conducted per round
   - At the conclusion of all rounds, every participant will have participated as counsellor, client and observer



3. The following instructions should be issued per round:
   - Instruct "*counsellors*" to use the detailed pre-test counselling guide in **HO12** to engage in the role-play for the different case studies
   - Observers should follow the observer's guide included in **HO12**. Observers are to observe the process of the role-play and provide feedback to the counsellor at the conclusion of the role-play
   - Facilitators should remind observers that they are not to interrupt the role-play
   - Each "*client*" is issued a case **(AS14)** and is asked not to share the details of the case with the counsellor or observer. They are permitted only to disclose if they are role-playing a client of a different gender. Emphasise that it is up to the counsellor to ask questions in such a way that they get the information from the client
   - Allow a maximum of 20 minutes for the role-play
   - At the conclusion of each round of the role-play, ask the triad to provide brief feedback to each other on what they experienced in the role-play. Allow 5 minutes only for this activity
   - This is to be followed by requesting the class to form three small groups. One small group should comprise trainees who played "*counsellors*" for that round, another should comprise all those trainees who played "*clients*" and the third group should comprise "*observers*". A co-facilitator should be allocated to facilitate each group. The small group facilitators should focus the small group discussion on the following three questions:
     1. What made the client feel comfortable?
     2. What microskills were particularly important for the counsellor to employ?
     3. How did the trainees manage to balance the provision of information with being responsive to the need of the client's emotions?
   - The small group debriefing should last no longer than 10 minutes after each round
   - Ask the group if they have any questions and remind them about the "question box"
   - Ask trainees to complete an evaluation form and place it in the "evaluation form collection box"

Case study 1

This is a case of a 35-year-old male. He is married and has two young children aged four and two. He has decided to have an HIV test on the suggestion of his doctor. This suggestion followed the recent diagnosis of gonorrhoea, a sexually transmitted infection, on his last visit to the doctor. He reluctantly reports that he often has sex with other men, the most recent occasion being three weeks ago. He reports that this usually occurs when he has been drinking alcohol and that he does not use condoms. His wife is unaware of his sexual practices. He does not use condoms with his wife. He most recently had sex with his wife two weeks ago. He is unsure what he would do if he tested HIV positive. He is particularly concerned with how he would tell his wife and how she may react.

Case study 2

This is a case of a 21-year-old male. He states he has heard about HIV from some of his friends and has started to worry about whether he may be infected. He reports having had unprotected sex with several different female partners. The most recent occasion was one week ago. Discussion also reveals that he has experimented with injecting drugs. He reports that the needles he used were shared and not cleaned between uses. He most recently experimented with drugs four months ago. He reports that since he has been worried about HIV, he has not been eating well and has had difficulty sleeping. He believes he would be rejected by his family and friends if he were to test HIV positive. He mentions that he has thought about suicide should he receive a positive result.

Case study 3

A 23-year-old woman presents for a HIV test as she has become worried that she may have contracted HIV from her former husband. She has heard that he is unwell and there are rumours in the village that he has AIDS. She last had unprotected vaginal sex with him two months ago. She recalls that during the last few months of their relationship he complained of feeling constantly tired and coughed a lot. Their relationship broke up when he left her for another woman. She has not had other sexual partners. She now suspects that he had other sexual partners when he travelled up country for work. The client's family are poor and live in a slum area; they are annoyed that she has not stayed with her husband. Her family members have indicated that they feel she should have stayed with her husband. She is not comfortable raising her fears about HIV with her family. The client is very upset and worried. She is convinced that she has HIV.

Module 2

Sub module 5.3: Pre-HIV test counselling

Session objectives

At the end of the training session, trainees will be able to:

- Apply knowledge of basic counselling microskills to the context of HIV pre-test counselling
- Integrate clinical risk assessment, HIV prevention education and counselling into HIV pre-test counselling
- Assess an individual's coping strategies and psychosocial support system
- Facilitate provision of informed consent by the client

Introduction

It is UN policy that pre-test counselling accompanies HIV test. UN policy states that HIV voluntary testing includes the provision of informed consent,[i] the maintenance of confidentiality and post-test counselling.[1] HIV pre-test counselling helps to prepare the client for the HIV test, explains the implications of knowing that one is or is not infected with HIV, and facilitates discussion about ways to cope with knowing one's HIV status. It also involves discussion of sexuality, relationships, possible sex and drug-related risk behaviours, and serves to help the client prevent infection. It also serves to correct myths and misinformation around the subject of AIDS.[2]

Counsellors conducting pre-test counselling are often working under pressure, which limits the time available for each client. Where time is short, it is necessary to concentrate on the task at hand – dealing with the issues around the test itself and the prevention of HIV transmission. Many individuals coming for possible HIV testing have other issues. It may not be appropriate to follow through on these in a pre-test counselling session. Clients often bring other issues into the pre-test counselling session, either knowingly or unknowingly.[3] Where this occurs, counsellors should either re-book the client to discuss these issues at another time, if appropriate, or refer the client to another service.

Pre-test counselling presents the counsellor with the challenge of balancing the provision of information, assessing risk and responding to the client's emotional needs.[4] Many people are afraid to seek HIV testing because they fear stigma and discrimination from their families and community. VCT services should therefore always protect an individual's need for confidentiality. Trust between the counsellor and the client is essential and this is developed through establishing a rapport and showing respect and understanding to the client.[5] The use of counselling microskills is important to build rapport and demonstrate a client-centred approach to the session.

It is suggested that counsellors have a summary of the detailed VCT process made available in their offices (as follows below). Such a summary would provide a single page "at-a-glance" list of the key headings included in the detailed procedures checklist.

The process of VCT pre-test counselling guide[6] (detailed version)

1. **Cross-check code numbers** on ALL forms against the client's code.

2. **Introduction and orientation**
   - Name, designation and role
     i.e. "My name is ……. I am a counsellor at this centre. My role is to discuss issues pertaining to HIV and AIDS and any other concerns that you may have"
   - **Confidentiality** (including discussion of sensitive issues) and anonymity
     i.e. "Whatever we discuss will remain within this centre. As you have used a code name and code number, no one will know you by name. We will also discuss sensitive issues, but feel free NOT to answer any uncomfortable questions"
   - **VCT process outline** – sessions, duration, testing procedures
     i.e. "Our services are for people who come to this centre without being forced. We will discuss for 30 to 45 minutes. If you decide to be tested, you will need to wait for 15 to 20 minutes for the results. You will need a further 20 to 30 minutes to discuss the results after that"
   - **Record taking by counsellor** [Client information record and result (CIRR) pre-test forms]
     i.e. "At the end of the session I will take down a few notes on our discussion for record keeping purposes"

3. **Demographic data collection**

4. **How did you learn about this site?** This information is important for social marketing of the VCT service.

5. **Reason for visit** i.e. why client decided to visit the centre.

6. **Basic facts about HIV and AIDS**
   - Check understanding of HIV/AIDS
   - Modes of transmission including mother-to-child transmission (MTCT)

7. Combined risk education and assessment self-risk. Give the following explanation for discussing sensitive issues:

> I need to discuss some things today that perhaps normally we wouldn't discuss with others. I need to discuss these things in order to be able to:
> 1. Give you realistic feedback about your risk of being infected – you may be worrying unnecessarily.
> 2. Ensure you know how to keep yourself and partner/s safe in future – different practices have different risks.
> 3. See if you have other potential health problems that this test will not identify – maybe I will need to do other types of tests.
> 4. Make appropriate treatment and care suggestions. If you are tested HIV positive it would be important for us to know we know when you most likely contracted HIV or any other infections as this may determine the type of care offered.
>
> *As you can see, these are some good reasons for us to talk openly about these things even though it may not be comfortable.*

The following are suggestions for managing risk assessment. ***You may use the detailed clinical risk assessment proforma addressed in the clinical risk assessment module*** (Module 2, sub module 5.2). Cultural and clinical issues will impact how this section is conducted.

- Exposure to risk – when, where, how (refer to clinical risk assessment)
- Sexual activity and age at first sex (if not sexually active, ask about oral sex)
- STI – specify whether the client has STI now, in last 3–12 months or before that
- Number of regular and non-regular sexual partners
- Condom use with regular and non-regular sexual partners
- Risk triggers – alcohol, drugs, stress, loneliness, money

Partner risk

- Concerns about HIV in partner/s
- Past sexual history
- Partner risk triggers
- Nature of employment
- Living together or apart
- If partner has other sexual partners
- Knowledge of partner/s' HIV status
- Future plans with partner
- STI in partner

8. Communication with partner/s

- Discussion about HIV and STI
- Discussion about risk reduction
- Discussion about testing
- Discussion about condoms and condom use

9. Risk reduction

- Risk reduction attempts (previous)
- Details of successful attempts
- Details of failed attempts/obstacles
  i.e. “What has been the most difficult part of reducing your HIV risk?”
- Assess condom use skills and condom demonstration
- Re-visit risk triggers for high risk behaviour
- Other risk reduction options
  i.e. “Tell me what would be easy for you to change and what would be more difficult for you. Why?”
- Discuss risk reduction and testing of partner and role-play
- Recap on the agreed risk reduction plan

10. HIV testing

- If client is not ready for testing emphasise that testing is OPTIONAL
- Assess history of testing and results obtained
- Explain HIV tests and possible test results
- Discuss meaning of positive, negative and indeterminate results
- Discuss how client would react to any of the above results
- Discuss what result the client is expecting today
- Assess suicidal ideation
- Discuss advantages and disadvantages of having an HIV test
- Implications of results to self, partner and family
- If client wants a test find out how they feel about taking the test
- If client does NOT want a test review, discussion and conclude the session

Do not forget to discuss the window period and the need, if applicable, for re-testing. You may wish to use the example that follows.

Example of an explanation to clients about the window period:

> When HIV infects a person’s body, their body realises HIV is a virus that should not be in the body.
>
> The immune system in the body begins to develop antibodies to try to kill the HIV and protect the person. The test used to check for HIV looks for these antibodies in the blood, and is called an antibody test.
>
> It can take up to 12 weeks after infection with HIV for these antibodies to develop.
>
> This means that an HIV test cannot guarantee a persons HIV status as negative if they have had any risk for HIV in the 12 weeks immediately before the test. This time period of 12 weeks before the test is called the ‘window period’.

11. Assessing support systems

- Who knows about the client's visit to the VCT service?
- Does partner know about the visit?
- Who does the client discuss personal issues with?
- Who would the client tell about their negative or positive HIV result? (Immediate relative, partner, others) Why, when, where, how?
- Expected reaction and management of reaction
- Expected support from persons taken into confidence
- Discuss or provide healthy living information, education and communication (IEC) materials – balanced diet; medical care; family planning; STI screening and treatment; opportunistic infection preventive treatment; malaria prevention; avoiding further re-infection; avoiding taking drugs, alcohol and smoking; exercise and rest; support and sense of optimism.

  i.e. "Healthy living means taking care of your health and your emotional well-being in order to enhance your life and stay well longer"
- Assess client's readiness for the test. If ready, obtain consent (thumbprint).
- Establish contract to spend 20 to 30 minutes for post-test counselling session

In Module 5, sub module 1 we will discuss how this model of VCT can be adapted to different service demands such as couples, counselling and group counselling.

References

[1] UNAIDS Policy on HIV testing and counselling (1997) http://www.unaids.org/publications/documents/health/counselling/counselpole.html
[2] UNAIDS (1997). Counselling and HIV/AIDS UNAIDS technical update. UNAIDS Best Practice Collection. Geneva.
[3] Kalichman, S. (1995) Understanding AIDS: A guide to mental health professionals. American Psychological Association. Washington.
[4] O 'Connor, M. (Edit) (1997) Treating the psychological consequences of HIV. Jossey-Bass Publishers.
[5] UNAIDS (2000). VCT UNAIDS technical update. UNAIDS Best Practice Collection. Geneva.
[6] Population Services International (2001) VCT site operation procedures manual, Zimbabwe.

Module 2

Sub module 5.4: Pre-HIV test counselling - Sexual assault

Session objectives

At the end of the training session, trainees will be able to:

- Identify circumstances where VCT workers may come into contact with survivors of sexual assault
- Understand what constitutes sexual assault and know some of the effects that sexual assault can have on the life of a survivor
- Identify the requirements for offering care to those who have been sexually assaulted
- Outline the steps to be taken once a sexual assault has been disclosed

Time to complete sub module

1hour 30 minutes

Training materials

- PowerPoint presentation **(PPT14)**
- Activity sheet (case studies) **(AS15)**
- Handout **(HO13)**
- Question box
- Evaluation form collection box

Content

- What constitutes sexual assault?
- Sexual assault and increased vulnerability to HIV and STIs
- How VCT workers come into contact with survivors of sexual assault
- The psychosocial impact of sexual assault and implications for counselling
- Steps to be taken once a sexual assault has been disclosed to the counsellor

Session instructions

1. Lecture with PowerPoint presentation **(PPT14)**
2. *Activity:* Brainstorm session.
   - What do you think are the effects of sexual abuse on the survivor?
3. *Activity:* Case studies **(AS15)**
4. Ask the group if they have any questions and remind them about the "question box".
5. Ask trainees to complete an evaluation form and place it in the "evaluation form collection box".

Case study 1 – Sexual assault (male)

This is a case of an 11-year-old boy. He is normally excited about going to school. Yesterday afternoon a teacher asked him to stay after school to help make some teaching materials for the next day's class. As the other students and teachers were leaving for home, he started working on the materials. The teacher came in the room and started complimenting him on his diligence and cleverness. Then he started to touch him in an inappropriate manner. When he tried to resist, the teacher forced him to the floor and sexually assaulted him. The boy was forced into being the receptive partner in anal sex. No condom was used and he had slight anal bleeding afterwards.

The next morning his mother noticed that he was hesitant to leave home for school. Later, she found blood in his undergarments as she was doing the washing. His mother went to the school to take him out of class to see a doctor. The doctor has referred the boy to be HIV tested. They are both very distressed about the assault and feel nervous about testing and what the results may be.

Case study 2 – Sexual assault (female)

This is a case of a 15-year-old girl. One week ago she was travelling home from work and was raped by a policeman. She was threatened with dire consequences if she reported the matter to anybody. She was referred to a physician with complaints of pain in the stomach and vaginal discharge and on a suspicion of being infected with HIV. The client is still in a state of shock. She reports the penetration was vaginal, anal and oral. She also has scratches and injury marks on her body.

Module 2

Sub module 5.4: Pre-HIV test counselling - Sexual assault

Session objectives

At the end of the training session, trainees will be able to:

Identify circumstances where VCT workers may come into contact with survivors of sexual assault
Understand what constitutes sexual assault and know some of the effects that it can have on the life of a survivor
Identify the requirements for offering care to those who have been sexually assaulted
Outline the steps to be taken once a sexual assault has been disclosed

1. Introduction

Sexual assault occurs in every society, country and region. It constitutes a violation of basic human rights and can result in long-term physical and psychological trauma.[1]

Testing should not be the first priority! Support, health service and forensics (with consent) come first.

2. Sexual assault and risk of HIV and STI infection

People who have been sexually assaulted may be at increased risk of HIV and STI infection due to the following:

- The tearing injuries and open wounds of the woman or man's genital tract from the use of force increases the risk of contracting HIV from an infected man
- Where the perpetrator belongs to a category that tends to have higher rate of STIs, prophylactic therapy using appropriate antibiotics should be considered to cover the major treatable infections, e.g. gonorrhoea and syphilis, which could otherwise have long-term consequences
- Co-infection with STIs may also increase the risk of HIV transmission
- Girls who have not completed puberty are particularly vulnerable to the effects of STIs as there is a risk of permanent damage such as infertility or ectopic pregnancies in the future

Often people who have been assaulted are worried about the possibility of HIV transmission so it is not uncommon that clients will come to VCT sites for testing.

Other ways in which VCT workers may come in contact with a victim of sexual assault may include:

- Cross-referral of person from other medical services
- Requests from sexual assault services
- Requests from community groups or organisations to counsel and test the person

What constitutes sexual violence?

There are various forms of sexual violence:

- Rape is the most common form. Rape is committed when a person's resistance is overcome by force or fear or under coercive conditions
- Insertion of objects into genital openings
- Oral or anal intercourse
- Attempted rape[2]

Sexual violence can also include the use of threat or force in order to have sexual acts performed by a third person. Sexual violence covers all forms of sexual threat, assault, interference and exploitation or molestation without physical harm or penetration.[1]

Sexual assault is often meant to hurt, control and humiliate, violating a person's innermost physical and mental integrity.[1]

What are some of the effects of sexual violence?

Physical consequences may include:

- Pains, nightmares, loss of appetite, headaches
- HIV infection
- STIs
- Pregnancy
- Miscarriage
- Mutilated genitalia
- Menstrual disorder
- Internal injuries
- Self-mutilation as a result of psychological trauma[1]

Psychological consequences:

- Signs of trauma include sadness, fear, confusion, loss of memory, attention problems, isolation
- Powerlessness
- Self-disgust
- Apathy
- Denial
- Inability to function in daily life
- Depression leading to chronic mental disorders
- Suicide
- Abortion of pregnancy as a result of rape
- Cases of infanticide of children born as a result of rape have also been reported[1]
- Additionally, lack of self-esteem post-assault may mean a lessor commitment to safer behaviours

Social consequences:

- Rejection by spouse or family members
- Stigmatisation or ostracism by the community
- Further sexual exploitation
- Severe punishment
- May also include deprivation of education, employment or other assistance or protection[1]

Persons most vulnerable:
- Unaccompanied women
- Lone female heads of households
- Unaccompanied children
- Children in foster homes
- Refugees or people in detention or detention-like centres[1]

3. Making preparations to offer care to persons who have been sexually assaulted

The health coordinator needs to ensure that:
- Local protocols are developed for the care of survivors of sexual assault, based on available resources, national policies and procedures (See below)[2]
- Health care providers, doctors, nurses, medical assistants, counsellors etc., are trained to provide appropriate care according to local and national policies and procedures[2]
- The clinic has the necessary equipment and supplies, including medications (See "Check list of supplies for clinical management of rape survivors")[2]
- The clinic has developed a referral network of agencies able to provide ongoing support to survivors of sexual abuse
- The clinic has developed relevant documentation including a consent form, data collection forms, referral forms, etc.

4. Developing local policy

- Involve a team of professionals who are involved in caring for people who have experienced sexual assault, e.g. counsellors, medical personnel
- Create and document referral networks between agencies and sectors, e.g. community, health, security and protection
- Identify special procedures relating to child survivors of sexual abuse
- Identify available resources (drugs, IEC materials, laboratory facilities and relevant national policies and proceedings related to sexual abuse e.g. standard testing and treatment protocols for STIs and HIV, legal proceedings, laws relating to abortion, PEP, or post exposure prophylaxis, etc)
- Identify the costs involved both client and centre, e.g. treatments, resources, etc.
- Identify requirements for legal proceedings, e.g. What forensic evidence is required? What documentation? Are there limits for submitting a report? Who bears the cost of legal proceedings — the State or the individual? Are there any procedures through which the client can apply for compensation, etc.[1]
- Develop situation-specific medical care protocol (Refer to annex of VCT forms, which includes "Clinical Management of Survivors of Rape" for minimum care for rape survivors in low-resource settings[2]
- Work with the community to raise awareness of services available[3]

5. Key differences in client presentation to VCT services

Survivors of sexual assault may not be forthcoming in disclosing incidents of abuse or sexual violence. Clients who have experienced sexual assault or violence may be:
- Highly emotional
- Anxious
- Depressed or
- Non-communicative and in shock.

In these cases it may be appropriate to check to see if clients have had coerced or non-consensual sex. [2]

Most incidents of sexual violence remain unreported for fear of shame, social stigma and fear of reprisal or the case going to trial. Other reasons for non-reporting include:

- Loss of family honour
- Community ostracism
- Possible detention and trial
- Further attacks by the perpetrator
- When men or boys are the clients
- When the perpetrator in a position of authority
- Inability to speak the local language[1]
- Male survivors often will not report or even acknowledge to themselves that they have been assaulted[2]
- Children may be extremely fearful and find it difficult to articulate what has happened[2]

When someone has the courage to come forward after a sexual assault it is important that health care workers know how to respond appropriately. An incident of sexual violence must be examined and assessed in a highly sensitive and confidential manner in order not to cause further suffering or further danger to the clients. [1]

The health care worker should establish the required action in each of the following areas:

- Protection: ensure the physical safety of the client
- Medical: prevent any further suffering by the client
- Psychological: including culturally appropriate counselling facilities and linkages to appropriate supports[1]

Once an incident of sexual violence has been revealed the following steps should be taken:

Step 1. Ensure the protection of the client's human rights:

a. The staff should provide emotional support to survivors of sexual assault. Staff should be sensitive, discreet, friendly and compassionate when dealing with the client.
b. Ideally, survivors of sexual assault should be referred to a sexual assault service that has VCT capabilities. Where this is not possible, or survivors decline to attend this service, try to ensure the client is seen by a health care worker of the same gender who has relevant training in crisis management and VCT.
c. DO NOT pressure them to talk if they do not wish to — simply make them aware that you will be available at any time if they should change their mind and wish to talk about it.
d. If they do wish to talk about the event, guarantee them confidentiality. Written information on the client should be kept secure in a locked area (lack of confidentiality could discourage others from coming for testing).
e. Ensure the person's privacy within the health facility (move to a closed office if necessary).
f. Assess the need for immediate medical assistance. If required refer to Step 3a.
g. Ensure the future safety of the client. This may include arranging safe housing for the person who has been assaulted. A family member or friend should also be housed with them for their support.
h. Then VCT staff should ascertain whether the survivor wishes to pursue legal charges. This will dictate the need for future forensic interview and examination. If the person does decide to pursue legal action then proceed to step 2.
i. If the survivor declines legal action the VCT staff need to ensure the client understands that future legal action may be less successful if forensic evidence is not collected at the time of initial presentation (in the case of a recent sexual assault).

j. Where the survivor declines forensic examination other services should be offered to the client such as counselling (See step 5), testing for HIV, STI and pregnancy, and available treatments discussed (in some countries post-exposure prophylaxis for HIV, STIs and other infection may be available).
k. DO NOT leave them alone for long periods[1].
l. Be guided by the best interests of the survivor but respect the person's wishes in ALL instances.

Step 2. Contact the police/authorities:

a. Advise the client about the likely course of events following police notification or notification of authorities, e.g. in refugee/detainee situation. These will differ for each country.
b. **If the client so decides,** the police/authorities should be contacted immediately and the proper documentation completed (See step 3b).[1]

Step 3. Medical:

a. **If the incident has occurred recently, the client may require immediate medical care.**

- If the medical care required is not within the capacity of the facility then the client should be escorted to appropriate medical facilities
- Ensure doctor is of the same sex as client; it could be culturally inappropriate to have a doctor of the other sex
- Injuries sustained during the attack should be treated
- Discuss the need for a medical examination and forensic interview. The health care worker will need to prepare the client — sometimes medical procedures themselves can be invasive and traumatic
- Staff should be familiar with the medical procedures and be able to explain these to the client before obtaining their consent

b. **The forensic interview**

Always obtain consent from the client (or parent/guardian if the client is a child) before conducting an interview (See annex on VCT forms). Make sure the client understands that the interview will involve detailed questioning about the event, which they may find upsetting to recall. However, the client should be informed that they do not have to answer any questions they feel uncomfortable with and they can stop the interview at any time. Assure the client that the interview will be private and confidential and that confidentiality can be total if the client does not wish anything to be done.

The interview should take place in an environment that is quiet, private, confidential and comfortable so that the client can feel at ease. It may be helpful to have some tissues and drinking water on hand. Where a child is being interviewed they should have the option of having a parent or guardian with them at the interview (See reference 2 and 3 for specific information on child victims of sexual abuse). The medical officer should try to ensure that there will be no interruptions during the interview. Notes should be taken discreetly during the interview — notes written afterwards are likely to be inaccurate.

The forensic investigation will include:

- Detailed questioning regarding the nature, context and circumstances of the assault. Previous sexual history is IRRELEVANT unless in relation to previous sexual attacks, which may have implications for the protection of the client. People who have experienced previous sexual attacks may be more prone to re-traumatisation during the interview.

- A risk assessment for HIV, STIs and pregnancy should be undertaken
- Responses to the questions should be documented thoroughly so that repeat questioning will not be necessary
- At the conclusion of the interview the client should be reassured of their safety, and any follow-up action explained clearly to them[1]

c. **The medical examination**

The medical examination should be witnessed. The actual procedures undertaken should be guided by the responses to question in the forensic interview. It may include:

- A medical history
- Documentation of state of clothing
- Collection of material which may serve as evidence, e.g. fingernail scrapings, swabs, saliva and blood samples
- Documentation of evidence of trauma, including photographs
- Complete physical examination, possibly including a pelvic examination

Consent for tests should be obtained. This may include consent to be tested for:

- STIs
- HIV
- HBV
- Other infections
- Pregnancy

Medical treatments may be offered according to local protocols:

- Analgesia
- Antibiotics for STIs
- Emergency contraception (if available)
- Tetanustoxoid injections

Pregnant women who have been sexually assaulted are physically and psychologically more vulnerable, being susceptible to miscarriages, hypertension and premature births. [1]

(Recommendations for conducting a medical history and examination are provided in the document "Clinical management of survivors of rape: A guide to the development of protocols for use in refugee and internally displaced person situations."[2] (See the annex of VCT forms for sample data collection form for medical examination.)

Step 4. Where VCT staff are NOT medical officers:

Other information, besides that collected in the forensic interview, may need to be collected for the purpose of determining what further action, if any, is required, e.g. medical help, legal help or other referrals.

Where possible, information should be collected on one form (See annex of VCT forms: Incident Report Form) so that duplication of questions is avoided.

Step 5. Referral:

a. *Community service workers*: These may provide clothing (so that the client can change the clothes worn during the attack) and essential items such as blankets, food, etc. [3]

b. *Counselling services*: The client should be advised of counselling services, if available. **Counselling should only be provided by trained mental health professionals.** They can provide counselling for post-traumatic effects, support for dealing with family and community reactions and emotional support throughout legal proceedings. [1]
c. *Services available for children*: Children are usually best referred to a paediatric hospital or clinic.
d. *Legal services*: If the client wishes to notify the police, they may need assistance in obtaining legal aid etc. In many countries these services are provided by NGOs.

Step 6. Follow-up:

a. *Counselling services*: Survivors of sexual violence are unlikely to remember counselling or advice given shortly after the event, so it is important to repeat the counselling in follow-up visits. It is also useful to prepare standard advice for survivors of sexual assault in writing so that it can be referred to later.[2] Timing of follow-up visits will be recommended by the counsellors.
b. *Medical services*: Follow-up testing for HIV, HBV and STIs will be required as the first tests undertaken at the initial visit only reflect baseline status. The timing of follow-up visits will be dependent upon the local testing capabilities and the respective window period of different infections.

6. Counselling for survivors of sexual assault

Common psychological responses to a sexual assault include:

- Fear, helplessness and humiliation
- Loss of trust, loss of sense of safety and security
- Guilt or shame
- Aggressiveness, destructiveness, anger or hatred
- Feelings of uncleanliness, unworthiness[1]
- Acute stress reactions, somatisation (early)
  - Post-traumatic stress
  - Change in eating habits, anxiety disorders
  - Stigma and silence
  - Depression and attempted suicide[2]

Initially, clients may experience “psychic numbing”: the person feels numb, shows little feeling or emotion, appears very calm and speaks inaudibly. This is one of the defence mechanisms that help the client to continue with their lives. Others include forgetting, denial and deep repression.[1]

After the initial shock and trauma of the events, the client may go through a period of thinking frequently about the incident. This can then bring on feelings of grief, anxiety, phobia, somatic problems and sometimes even serious chronic mental conditions.[1]

There is a high correlation between sexual assault and suicide attempts. Suicide risk assessment should be conducted over several visits. Ideally, visits should occur near the time of the event, two-weeks after the event and again at six-months.[2]

7. General principles of counselling people who have experienced a sexual assault

- Where possible, counsellors should work as part of a team with trained health and welfare workers, other service providers and members of the community
- Counselling should be offered to the client but they should not be pressured to undertake it
- Counselling is more effective when the person is ready for it

- Counselling should be carried out as soon as possible by health care professionals with appropriate training, e.g. in the field of pre- and post- test counselling, where the client has agreed to HIV testing, and crisis management
- Counsellors should practise active listening, all the time respecting the survivor's wishes and choices and maintaining the survivor's confidentiality
- Immediate intervention can help to minimise the severity of psychological trauma in the long-term[1]

Objectives of counselling

Counselling can have the following benefits for people who have been sexually assaulted:

- Help clients to develop a sense of control over their lives and to overcome their feelings of guilt
- Help clients to realise they are not responsible for the attack, to stop blaming themselves and to understand that they are not alone and that many other people have overcome similar experiences and still lead normal lives
- Help clients to understand feelings of anger and fear and to help them express anger towards their attacker in order to alleviate feelings of self-blame
- Help to break the client's feelings of isolation by linking them to support groups and networks and helping them to integrate into community activities[3]
- Support the survivor in resolving family and community disputes (where appropriate)

Where sexual violence has occurred within the domestic situation, counsellors need to be mindful that the client may decide to return to the perpetrator (or have no alternative). It is best to provide discreet advice on any options available to the client.[1]

Most survivors of sexual assault can regain their psychological health through emotional support, social support and psychological counselling, which are essential components of care for the survivor of sexual assault.

References

1 UNHCR "Sexual violence against refugees: Guidelines on prevention and response. " Geneva, 1995 [www.unhcr.ch]
2 Inter-agency. Clinical management of survivors of rape: A guide to the development of protocols for use in refugee and internally displaced persons situation. An outcome of the inter-agency lessons learned conference: Prevention and response to sexual and gender-based violence in refugee situations. 27-29 March 2001. Geneva
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Module 2

Sub module 5.5: Pre-HIV test counselling - Occupational exposures

Session objectives	At the end of the training session, trainees will be able to: Adapt VCT process to the specific VCT context of management of occupational exposures
Time to complete sub module	2 hours 30 minutes
Training materials	PowerPoint presentation **(PPT15)** Activity sheet (case studies) **(AS16)** Handout **(HO14)** Question box Evaluation form collection box
Content	Introduce HIV pre- and post- test counselling sessions Flowchart for VCT in management of occupational exposures Post-exposure prophylaxis (PEP) counselling Source testing

Session instructions

1. Activity:
   - Ask participants if they are at risk of occupational exposure. Ensure that police, cleaners in hospitals, garbage handlers as well as health workers (laboratory technicians, phlebotomists, nurses, doctors, etc) are included
2. Activity:
   - Ask trainees to write on a piece of paper whether or not they have an occupational exposure (i.e write 'yes' or 'no'). NO NAMES should be written on the paper
   - Collect the responses and assess the magnitude of the problem within the group
3. Activity:
   - Brainstorm a list of occupational exposures and the first aid actions that one would take to reduce the risk of infection
4. Lecture with PowerPoint presentation **(PPT15)**.
   - Outline and explain that there are three types of counselling in the management of occupational exposures (1.Post-exposure prophylaxis counselling, 2. Pre-HIV test counselling, and 3. Post-HIV test counselling)

- Lecture on the steps involved in the management of occupational exposure

5. *Activity:* Case studies **(AS16)**
   - Role-play one of the cases in front of the group
   - Work with two groups by identifying the key issues and key strategies of the case (one facilitator per group)
6. Ask the group if they have any questions and remind them about the "question box".
7. Ask trainees to complete an evaluation form and place it in the "evaluation form collection box".

Special note for facilitators

A few cases are listed below. Facilitators' de- briefing notes follow each case but these should not be provided to the trainees. Rather they should record their own responses to encourage active listening in the debriefing exercise.

Case study 1

A 30-year-old female nurse comes for an HIV test after blood exposure to the eyes during assisting in the delivery of a baby. This occurred two days ago. She is there for a baseline test. She has two children aged seven and five respectively, and has been married for the last 10 years. She believes her relationship with her husband to be monogamous.

She is highly anxious and wishes to know the status of the patient. She reports that her husband is very concerned for her and is inclined to worry a lot. She doesn't reveal any pre-morbid psychological disturbance. She indicates her family would be supportive if she tested positive, however, she is unclear how her work colleagues would respond (many of her immediate colleagues are aware of the exposure).

Case study 1: Debriefing notes

(For facilitator use only. Not to be included in the participant handout.)

Key issues	Strategies
Blood exposure to the eyes two days ago	• Check to see what first aid was performed to mitigate risk e.g. did they flush eyes with water. • Conduct exposure risk assessment and advise low risk PEP counselling if applicable.
Presenting for a baseline test	• Offer baseline test. Indicate to the nurse that this test will only ascertain if she was HIV positive at the time of exposure . • Remind her this test can in no way inform her whether she became infected as a result of exposure. • Advise her that she will require follow-up testing to cover window period. • Advise her that as this is a baseline test, and as it involves personal risk she may wish to have an anonymous test elsewhere first. • Conduct normal pre-test counselling and risk assessment

HIV status of the patient unknown. Has a belief she has a right to knowledge of the patient's status.	• Advise that she should not request or pressure the source patient. Another staff member can request the test. The patient has a right to decline. The patient has a right not to permit her to know status· • Remind her testing the patient may not fully relieve her anxiety. May be within the window period. If s/he is known to be positive it is not a forgone conclusion that she will be infected.
Husband's status unknown but believes him to be monogamous.	• Gently remind her that whenever we have unprotected sex with a partner of unknown status there can be no absolute guarantees, even though the risk may be low. Explain that is why you need to conduct a personal risk assessment. • Advise her to practise safer sex until her *final* test result related to the occupational exposure is known but remind her the occupational risk is low.
She is highly anxious.	• Advise her that in the unlikely possibility her test is positive that you can assist her in developing deciding how to discuss with her family.
Husband worries a lot.	• Suggest husband comes in for counselling with her. He can then be advised that the exposure risk is low.
Family would be supportive if she tested positive.	• Advise her that in the unlikely possibility her test is positive you can assist her in deciding how to discuss with her family.
Unclear how colleagues would respond. Many know she has had an exposure.	• Advise her on strategies to reduce the concerned enquiries about how her test result went. • Coach her in providing evasive verbal and reassuring responses during waiting time for baseline result. • Advise her that if baseline is positive you can assist her in developing strategies. • Reassure about confidentiality.

Case study 2

A female nurse has had a needle stick injury whilst performing venepuncture. The accident occurred one hour ago. She is very distressed. The patient is known to have HIV. The needle only just penetrated the skin of the nurse and was not deep. She was not wearing gloves whilst performing venepuncture.

The nurse is single and not pregnant. She is worried about being "banned from nursing" until her results come back. She does not want anyone to know but the hospital regulations state she must fill out an incident report. She fears the laboratory will not respect her confidentiality. She is also fearful colleagues who fear HIV will reject her.

Case study 2: Debriefing notes

(For facilitator use only. Not to be included in the participant handout.)

Key issues	Strategies
Exposure one hour ago	• Check about first aid - assess and advise.
Needle stick injury whilst performing venepuncture	• Perform exposure risk assessment.
The needle only just penetrated the skin of the nurse and was not deep.	• Advise and emphasise that risk is low due to reduced with the minimal penetration.
The patient is known to have HIV.	• The health worker is not automatically entitled to know the status of the patient. However, the doctor who is treating the exposed worker may have access to the patient's status in order to make appropriate clinical interventions.
The nurse is single and not pregnant.	• Double check whether contraception is being used if sexually active and check for pregnancy if indicated and permission is obtained.
Worried about being *"banned from nursing"* until her results come back.	• Advise the nurse to avoid "exposure prone" procedures such as episiotomy, dental work. Assist health worker in engaging in other duties. Most nursing duties will not be considered exposure "prone" procedures.
She does not want anyone to know.	• Inform the nurse who needs to know about her exposure. This should be restricted information only very key personnel should know.
Must fill out an incident report.	• Ideally policies should have linked "anonymous" codes on incident forms. Advise if this is not the case.
Fears the lab will not respect her confidentiality.	• Code lab forms. Advise her on confidentiality measures that are in place. Ensure such procedures are in place in agency protocols. • Refer to anonymous VCT service for baseline test.
Fearful that colleagues who fear HIV will reject her.	• Discuss strategies to reduce the number of people knowing about the incident, and how to manage enquiries such as "how did your test result go?" Rehearse replies. Discuss strategies for making decisions about disclosure of information (who, why, where and how to disclose).
She was not wearing gloves.	• Provide information on how to avoid future exposure. Review the exposure to ascertain if procedures could be improved. Advise gloves reduce the risk of penetration and exposure.

Module 2

Sub module 5.5: Pre-HIV test counselling - Occupational exposures

Session objectives

At the end of the training session, trainees will be able to:

Adapt VCT process to the specific VCT context of management of occupational exposures

1. Introduction

Many health, laboratory, social[1] and ancillary[2] workers may be at risk of occupational exposure to HIV and other infections. It is important that these workers receive education about the process to follow should they sustain an occupational exposure. Often health workers who have had an occupational exposure report it at the time of exposure but they have no clear idea about what steps should be undertaken.[3] People who have sustained a significant exposure risk should be assessed for post-exposure prophylaxis (PEP) and PEP should be administered within 24-36 hours and preferably within a couple of hours of the exposure.[4,5] Often health workers are in a state of crisis, which means testing is given priority over counselling. Health workers are also frequently tested without counselling or informed consent; many receive inadequate information on the benefits and potential difficulties they may face while receiving PEP, and confidentiality is often breached.

2. The risk of infection

The average estimated risk of HIV infection for health care workers following percutaneous or mucous exposure is less than 0.5% in incidence studies[6], although a case controlled study suggests it is higher for the highest risk percutaneous exposure. The majority of documented exposures occur in nurses after contact with blood of a patient with AIDS by means of percutaneous exposure, with a device placed in an artery or vein. Transmission through splashes, cuts, and skin contaminations is also possible, although there is a comparatively low risk of infection. In addition to exposure risk assessment for HIV, health workers should be assessed for HBV and HCV exposure as well as other blood-borne pathogens.

3. The baseline HIV test – special considerations

The initial HIV test following exposure will be a baseline test for monitoring potential seroconversion after exposure. This initial test therefore will only reflect previous exposure arising from the workers personal risks. In high prevalence countries many people will have a seropositive HIV test result at this stage, as the HIV prevalence of health workers, for example, often reflects prevalence in the general population. It is therefore important that the health worker is informed of this, and that an individual personal risk assessment is conducted. Conducting a baseline test on a health worker may be carried out in another location other than the place of work, such as an anonymous testing clinic to assist in maintaining the confidentiality of this information. If at a later stage the worker requires proof

that they tested negative at the time of the exposure then that can be given to the employer with the health worker's consent.

4. VCT in the context of the management of occupational exposure[7]

4.1. First aid occurs prior to any counselling or testing if the worker presents immediately after sustaining any injury. This may include, for example, washing with cool mild soap or a dilute hypochlorite solution.

4.2. An exposure risk assessment is then conducted. This should focus on a detailed analysis of the nature of the exposure (wound depth, type and quantity of body fluid, etc). The source patient may be requested to test, but should only be approached by a health worker other than the one who sustained the exposure.

Immediately after the accident exposure, the doctor or another designated HCW should evaluate risk of infection according to:

- Severity of the exposure
- Depth of injury
- Duration of exposure
- Type of instrument/needle involved (hollow bore or suture needle)
- Serological status of the patient
- Stage of disease (symptomatic/asymptomatic, high/low viral load or CD4 count) of the source patient
- Zidovudine (ZVD**)** or other ARV resistance in source person, if on anti-retroviral treatment

Taking all the above components into consideration, the type of exposure could be:

1) Massive
2) Intermediate
3) Minimal

Type of exposure	Symptomatic and/or high viral load	Asymptomatic and/or low viral load
Massive	PEP recommended	PEP recommended
Intermediate	PEP recommended	Possible
Minimal	Possible	Possible (to be counselled about options)

4.3. Testing of the source patient should only occur where the patient has access to pre- and post-test counselling. If the source patient is being treated for a non-HIV condition it may be useful to enquire if they have or are taking medication prescribed for HIV, and if so, find out the specific medication.

4.4. PEP should only be prescribed after obtaining informed consent from the health worker. This involves feedback of the exposure risk assessment, information on the potential benefits and problems associated with taking the medication and exploration of the potential constraints to adhering to the regime and the provision of some strategies to manage the difficulties.

WHO recommended therapeutic regimens for resource poor settings

PEP should be commenced as soon as possible after the incident and ideally within 2-4 hours. However, there is no time limit in most country recommendations. Prophylaxis is sometimes given empirically after up to two weeks in the case of severe exposure when the delay has been unavoidable. Combination therapy is recommended, as it is believed to be more effective than a single agent. Dual or triple drug therapy is recommended, depending on the type of exposure and status of the exposure source.

The therapeutic regimen will be decided on the basis of drugs taken previously by the source patient and known or possible cross-resistance to different drugs. It may also be determined by the seriousness of exposure and the availability of the various ARVs in that particular setting. The combination and the recommended doses, in the absence of known resistance to ZVD or 3TC in the source patient, are:

Minimal – intermediate exposures

- ZVD 250-300mg twice a day
- 3TC 150 mg twice a day

Massive exposure

If a third drug is to be added

- Indinavir 800 mg thrice a day or efavirenz 600 mg once daily (not recommended for use in pregnant women)

Provision of ARV therapy (ART) should be provided according to institutional protocol (and made available as a PEP "kit") or when possible, via consultation with a medical specialist. Expert consultation is especially important when exposure to drug-resistant HIV may have occurred. It is important that health care workers have ready access to a full month's supply of ARV therapy once PEP is begun. A treatment of four weeks' duration is recommended. A trained ARV-prescribing physician should make decisions with regard to the appropriate regime and dose for the individual.

4.5. **Pre-test counselling** should precede any baseline blood testing. The health worker must be informed that the initial test will only reflect their status at the time of the injury and therefore reflect their personal risk history. It is therefore suggested that a confidential personal risk assessment be conducted. For privacy reasons a health worker may opt to have this baseline test conducted elsewhere and provide the results to the employer only if a subsequent follow-up test shows that seroconversion has occurred.

4.6. It is important to remind workers to attend **follow-up testing**. This sequence should take into account the different seroconversion periods for different infections, and if the worker is to undergo PEP, take into account the longer seroconversion period that may occur.

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

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

- Fear of colleagues seeing them take medication and assumptions being made about their HIV status

- Side effects making it difficult to work – many health workers work long and intense hours
- Daily confrontation with patients who have HIV or advanced AIDS may cause an over focus on the potential for seroconversion and HIV illness
- If pregnant, the health worker may be anxious about impact of the regimes on the foetus

4.8. **Exposure risk reduction education.** Counsellors should review the sequence of events that preceded the exposure in a sensitive and non-judgmental way. This can assist with advising the worker on ways to protect themselves from future exposures.

4.9. **Counsel staff on post-exposure procedure protocols** for documentation of the exposure.

Summary service flow for VCT in the management of occupational exposure

1. **First aid:** Was it performed? If not, advise on first aid if exposure just occurred.
   - e.g. for needle stick, bleed wound and wash wound with mild soapy water.
   - e.g. blood splash to eyes, flush eyes with sterile water immediately.

2. Exposure risk assessment and feedback on risk (ESSE).
   - Use the four principles of transmission (**E**xit, **S**urvive, **S**ufficient, **E**nter).
   - e.g. consider whether needle was hollow bore, splash was on unbroken skin, etc.

3. **Prophylaxis counselling** – including informed consent for ARVs
   - Evidence for intervention
   - Discussion of the potential side effects
   - Prolonged window period
   - Adherence issues

4. **Pre-test counselling** – all the normal pre-test counselling and:
   - Education on how to reduce future occupational exposure
   - Procedures for testing to cover window period
   - Formalities for worker's compensation, insurance, etc.
   - When to present for follow-up test

5. Blood drawn for baseline test

6. **If HIV rapid tests are used** - Post-test counselling

References

[1] Police, custodial care officers, home-based care volunteers, etc.
[2] Cleaners, ambulance or rescue workers
[3] Tannebaum, J Anastoff, J (1997) The role of psychosocial assessment and support in the occupational exposure management. AIDS Education and Prevention
[4] CDC (1998) Public health service guidelines for the management of health worker exposures to HIV and recommendations for post-exposure prophylaxis. MMWR (RR-7);1-28 on http://wonder.cdc.gov/wonder/preguid/m0052722.
[5] CDC(1998). Recommendations for prevention and control of Hepatitis C virus(HCV) infection and HCV related chronic disease. MMWR 47 (RR19); 1-3
[6] Ippollito,G;Puro,V., Heptonstall,J,Jagger,J, de Carli,J. and Petrosillo, N. (1999) Occupational human immunodeficiency virus infection in health care workers : Worldwide cases through September 1997 Clinical Infectious Diseases 28:365-83
[7] World Health Organization Post Exposure(2001)http://www.who.int./hiv/topics/prophylaxis/en/print.html

Module 2

Sub module 6: Post-HIV test counselling

Session objectives

At the end of the training session, trainees will be able to:

- Apply a knowledge of basic counselling techniques used in VCT
- Understand the basic requirements for the provision of HIV results
- Conduct a post-HIV test counselling session for a negative result
- Conduct a post-HIV test counselling session for a positive result

Time to complete sub module

4 hours

Training materials

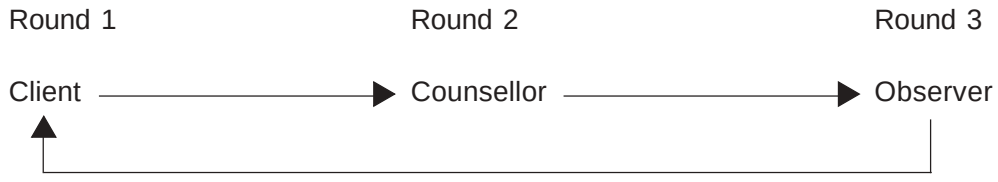
- PowerPoint presentation **(PPT16)**
- Overhead transparency sheet for activity (B), projector and screen
- Activity sheet (case studies) from previous pre-HIV test counselling sub module **(AS14)**
- Handout **(HO15)**
- Question box
- Evaluation form collection box

Content

- General principles for counsellors to follow in giving results
- Negative result provision
- Positive result provision
- Rehearse post-HIV test counselling

Session instructions[i]

1. Activity (A):
   - Ask the group what they would require of a VCT service if they were presenting for HIV test results. Keep discussion to not more than 5 minutes
2. Lecture with PowerPoint presentation **(PPT16)** on the general principles, allowing trainees to contribute and elaborate on the key issues.
3. Activity (B):
   - Inform the trainees that you are now going to move to training on post-test counselling for positive results. Inform them that you plan to introduce the topic with an experiential group activity
   - Note that this activity makes no assumptions about the trainees' HIV status and that you recognise that this may raise personal issues for the trainees. Offer an opportunity for the trainees to engage in a confidential debriefing session with a workshop facilitator should the need arise. This is an important statement to make to the group, as there may be trainees or someone close to them who has been diagnosed with HIV
   - Position the overhead transparency sheet for results onto the overhead projector without turning the projector on. Inform the trainees that you will now briefly switch off the lights for part of the activity B. The master sheet for the overhead is attached to this session plan from which the trainer can copy onto an overhead transparency
   - Ask trainees to think back to their first job and career progression to this day and to think about their plans for the future in terms of professional growth, family members and relationships, etc., for about 5 minutes. Ask them to visualise family members, partners and colleagues
   - Switch on the lights and turn on the overhead projector. Ask trainees to note the emotions they would have experienced had they been told that they were HIV positive. They are not to reflect on how the clients would react but how they would react
   - Ask trainees to share with the group their emotions and thoughts that they had in this activity
   - List and discuss their "needs" at the moment of being informed of their HIV results, bearing in mind the items on the "emotions" and "thoughts" list
   - Emphasise that the exercise that has just been completed illustrates what goes through the minds of HIV-positive clients when they receive their results
   - Discuss the implications of these emotions on the type of counselling that needs to be conducted at this stage
4. Using **PPT16**, make a 15-minute presentation on "Provision of HIV positive results".
5. *Activity:* Role-play of post-HIV test counselling
   - Inform the trainees that they will now engage in a role-play of post-HIV test counselling for HIV positive results. Organise the class into triads. Each triad is to comprise a "counsellor", "client" and "observer". Explain that all trainees will rotate between "counsellor", "client" and "observer" roles



[i] As this is a highly emotionally charged topic, it is recommended that this sub module be subdivided into a minimum of 2 sessions. It is suggested that a meal break divides this sub module.

- There will be three rounds of cases. One case is to be conducted per round. Advise the trainees that they will use the same three pre-HIV test counselling cases issued earlier **(AS14)**
- Round 1 of role-plays should commence with role-playing case 1 of the pre-HIV test counselling cases (in **AS14**), round 2 should use case 2 of the pre-HIV test counselling cases (in **AS14**)and round 3 should use case 3 of the pre-HIV test counselling cases. The client can share the details of the case with the counsellor and observer
- Allow a maximum of 20 minutes for the role-play

6. The following instructions should be issued to the trainees for each round:
   - One person in each triad is to take on the role of counsellor; the others take on the role of client and observer
   - Instruct "counsellors" to use the post-HIV test counselling guide on page 4 of HO 15
   - Observers are to observe the process of role-play and provide feedback to the counsellor at the conclusion of the role-play. Facilitators should remind observers that they are not to interrupt the role-play
   - At the conclusion of each round of role-play, the triad is to debrief each other (5 minutes)
   - This is to be followed by requesting the class to form three small groups. One small group should comprise trainees who played counsellors for that round, another should comprise trainees who played clients and the third group should comprise observers. A co-facilitator should be allocated to facilitate each group. The small group facilitators should focus the small group discussion on the following three questions:

1. What made the client feel comfortable?
2. What microskills were particularly important for the counsellor to employ?
3. How did the trainees manage to balance the provision of information with being responsive to the needs of the client's emotions?
   - The small group debriefing should last no longer than 10 minutes in each round
   - Reassure the group that provision of positive results is difficult but that it improves with practice, debriefing and clinical supervision
7. Activity:
   - End this session with an activity to break tension, e.g. a game of "Knots". Ask the group to form a large circle. Ask trainees to close their eyes and walk into the centre of the circle keeping their eyes closed with arms outstretched. Ask trainees to grasp hands of other trainee's without opening their eyes. Without opening their eyes they are to grab another trainee's hand with their left hand and then another trainee's hand in their right hand. Ask the trainees to keep holding the hands and open their eyes. The group task is to unravel the knot to form a circle again without letting go of the hands they are holding
   - This activity requires a shift of focus, group cooperation and typically results in a lot of laughs. Where it is culturally improper to engage in such an activity, ensure that trainees have some form of physical and mental stress release after this session
8. Ask the group if they have any questions and remind them about the "question box".
9. Ask trainees to complete an evaluation form and place in the "evaluation form collection box".

Refer to following page for activity sheet master to make overhead transparencies for activity B.

Emotions	Thoughts	Needs at this moment

Module 2

Sub module 6: Post-HIV test counselling

Session objectives

At the end of the training session, trainees will be able to:

- Apply knowledge of basic counselling techniques used in VCT
- Understand the basic requirements for the provision of HIV results
- Conduct a post-HIV test counselling session for a negative result
- Conduct a post-HIV test counselling session for a positive result

Overview of post-HIV test counselling

Post-test counselling helps the client understand and cope with the HIV test result. The counsellor prepares the client for the result, gives the result and then provides the client with any further information required, if necessary referring the client to other services. The counsellor further discusses strategies to reduce HIV transmission. The form of the post-test counselling session depends on what the test result is. Where the result is HIV antibody positive, the counsellor needs to provide the result in a manner that the client can comprehend, and as gently and humanely as possible, providing emotional support and assisting the client to develop coping strategies. Counselling is also important when providing an HIV negative result. Whilst the client is likely to feel relief, the counsellor must also emphasise and clarify a few important issues. It is important that counsellors are aware of any potential exposure risks that occurred within the window period and inform clients that they should practise safer sex until their HIV status can be clarified by a subsequent test. Clients should be informed of the need for and date of retesting. The counsellor can assist the client in further formulating a strategy to remain HIV negative.[1,2]

The foundation of good post-test counselling is laid during pre-testing counselling. If pre-test counselling is done well the counsellor will already have a relationship with the client, laid the ground for any necessary changes in behaviours or planning for the future, and will know quite a lot about the client. The client presenting for HIV test results is likely to be anxious, and those receiving positive HIV antibody test results will usually be distressed. It is therefore desirable that, where possible, the counsellor who provided pre-test counselling also provides post-test counselling.[3]

2. Key considerations for post-HIV test counselling

2.1. Cross-check all results with client files. This should be done prior to the counsellor meeting with the client. This will ensure the correct result is provided to the client.

4.2. Provide results to the client in person. Results should always be provided to the client in person. Providing the result to the client in person not only ensures that the correct person

receives the results, and the client's confidentiality is protected, it also ensures that the client has an adequate understanding of the result and receives appropriate support.[4] [5]

2.3. Be aware of the manner in which you call clients from the waiting area. A counsellor may unwittingly convey a result to a client and the others in the waiting area by their verbal and non-verbal behaviour when calling clients to receive their results.

2.4. Provision of written test results. Sadly, in many settings test results may be subject to either, improper or deliberate misuse. It is generally inadvisable to provide written results to clients, whether they indicate an HIV negative or positive status. In some settings positive test results are used to access services that others in the community may not be able to access and therefore become a commodity to be traded. HIV negative results may be offered to sexual partners and mislead those partners about the person's exposure risk.

Where a result is required for employment or immigration purposes and VCT is not offered as an anonymous testing service it is recommended that clients be asked for proof of identity at the time of test and again at the point of issue of the results. All results provided under these circumstances should contain a disclaimer that clearly informs the reader that the results may not accurately reflect the status of the individual as they individual may have had an exposure within the window period or after taking the test.[6]

Where clients wish to share results with a partner they should be advised to make an appointment with the partner and the result may be shown to the partner in the client's presence.

5. Guidelines for the provision of HIV-negative results

- Remember all of the above mentioned issues
- Check for possible exposure in window period – those undisclosed in pre-test counselling and risks that may have occurred since pre-test counselling (if same day results are not provided). *Clients may be HIV negative on a test result but may be in the process of seroconversion that could be highly infectious!*
- Reinforce information on HIV transmission and personal risk reduction plan
- Review and explore any constraints to the practice of safer sex, infant feeding issues (if breastfeeding) and, where appropropriate, safer injecting practices
- Referral for anxiety, i.e. "worried wells". — these are people who fail to believe results are HIV negative and often become frequent testers. Reassure the client but ask if they have hidden any significant risks within the window period since pre-test counselling — sometimes this is why people find it hard to relax with an HIV-negative result

6. Some general concerns that HIV-negative clients may present to counsellors

- Clients may be worried that other people will know they have had a test and make judgements about their behaviour. It is important that counsellors address these fears with the client and assist them in developing appropriate communication strategies with these people where practicable
- Some clients may express fears that employers or insurance companies will discover and act on the fact that an employee has had a test and therefore should be regarded as a "risky" person. Counsellors can reassure clients of confidentiality procedures that are in place within their VCT service

- Clients leave the service knowing that they have to modify their behaviour but some feel that this will be difficult because their partners will make it difficult for them. Counsellors are advised to encourage these clients to bring their partners to the service for couple counselling
- Some clients who have had high risks but not become infected will think they are immune and therefore keep wanting to practise unsafe sex

7. Frequent HIV-negative testers

Many clients have difficulty believing the test is actually HIV negative. This is often the case where clients have engaged in either high-risk behaviour or engaged in activities that they feel are wrong. For some individuals a negative test result is not enough to remove deep-seated anxiety and the belief that they are actually infected with HIV.[7] Some may question their result and discuss their symptoms, which they believe to be HIV-related. If reassurance does not reduce anxiety, and repeated requests for retesting occur, referral for specialist psychological/psychiatric/mental health follow-up should be considered. These clients may be exhibiting a significant psychological disorder[8] such as an obsessive compulsive disorder or hypochondriasis.[9]

8. Positive result provision and post-test counselling

An antibody positive result is likely to be the first of a number of crisis points in the course of HIV disease. Reactions vary widely, with some clients reacting with severe shock and obvious distress. Others respond with little reaction demonstrating blocked effect.[10] It is also possible that some clients may have anticipated that their result would be positive or have tested previously and therefore react with apparent calm acceptance.

Due to the trauma associated with the result, the counsellor needs to offer a safe, empathic and accepting environment to allow the client to discuss their feelings and thoughts.[11] Sufficient time should be allowed for the clients to focus and explore their emotional reaction. The counsellor should avoid giving false reassurances and should give the client the opportunity to acknowledge their legitimate fears. Clarification of misinformation about the meaning of the result and its implications is essential. This should include discussion of HIV disease, especially the distinction between HIV and AIDS. Assessment of support available to the clients is imperative. In the absence of such support there should be appropriate referral to counselling services or support groups and clarification of what support your VCT service can and cannot offer on an ongoing basis.

It is important that the counsellor enquires about, and assists the client in formulating immediate concrete plans for returning home from the VCT service and how they will cope during this period of crisis.

9. Counselling checklist for the provision of an HIV-positive result

☑ Be aware of non-verbal communication when calling client to the counselling room.
☑ Check client details.
☑ Confirm the client is ready to collect their result.
☑ Reinforce confidentiality.[12]
☑ Be clear and direct.
e.g. "*I need to tell you your result has come back HIV positive. This means you are infected with the HIV virus.*"
☑ Allow time to absorb the result
- Silence

- Check what the client understands by the result
- Gentle enquiry to discuss the meaning of the result for the client
  "*I'm wondering what you're thinking or feeling right now…"*
- Encourage expression and ventilation of emotion (normalise, validate)
- Suicide risk – Complete assessment and management if required
  (See Module two sub module 7 for information)

☑ Provide brief information about:
- Follow-up and support available
- 24-hour contact
- Back up verbal information with written information

☑ Concrete planning
- Support systems and disclosure (who, what, when, how and why)
- Leaving the clinic, getting home
- The next 48 hours (help the client to structure)
- Pre-existing coping strategies
- Ethical partner disclosure[13]

☑ Remember to ask if the client has any questions
- Cue clients to write future questions

☑ Arrange follow-up session or referrals as required

10. Managing client emotional responses[14]

Crying: If the client breaks down and starts crying, it is important to let them cry. Give them space to ventilate these feelings. Offering them tissues is a way of telling it is okay to cry. Comment on the process, '*This must be difficult for you, would you like to talk about it? Would you like to tell me what is making you cry?'*

Anger: The client might start swearing or exhibit outbursts of anger. Do not panic, stay calm and give the client space to express their feelings. Acknowledge that their feelings are normal and let them talk about what it is making them angry.

No response: This could be due to shock or denial or helplessness. Check that the client understands the result. Be on the alert for suicidal thoughts.

Denial: This could be verbal or non-verbal. Counselling should acknowledge client's difficulty in accepting the information. Let them talk about their feelings.

11. Follow counselling tasks

Encourage the client to ask questions. Be prepared to answer any questions honestly and with as much detail as is required. Don't be embarrassed to say you don't know some of the answers.

At some point an HIV-positive client will need information on the following aspects:
- Health, rest, exercise, diet (life style)
- Safe sex
- Infection control in the home and other social gatherings

You will need to carefully judge how much information should be provided at the post-test counselling session. Most of these issues can be addressed in follow-up sessions.

Offer follow-up counselling sessions. In these sessions the counsellor focuses on how the client is coping with the positive status or how they are managing to maintain the negative status. Infant feeding options are also discussed. Follow-up sessions are supportive sessions where client's concerns are dealt with.

Initial follow-up counselling visits may cover:

☑ Answer questions
☑ Assessment of impact of diagnosis
- Relationships
- Occupational
- Sexual
- HCW patient interaction

☑ Problem solving
- Disclosure to sexual partners and others
- Legal
- Workplace
- Sexual

☑ Decisions regarding treatment, etc.
☑ Review of support services
☑ Referral if required

What is the health worker's responsibility when clients refuse to disclose their HIV status to sexual partners and expose them to the risk of HIV?[15, 16]

- Consent to disclose an individual's HIV status to a third person (e.g. referral agency, a health worker not directly involved in a client's care, or the sexual partner of the infected person) should always be obtained. This may be written or verbal and should be noted on the medical/counselling record
- Ethical partner counselling also takes into account the serious consequence of **not** counselling partners about possible HIV infection. This consequence requires an ethical weighing of the benefits and harm that are likely to occur if and when there is refusal on the part of an HIV positive person to counsel partners, e.g. case of HIV-infected person having a demonstrated history of being a victim of domestic violence, or having their life threatened
- In the light of the possible transmission of HIV, UNAIDS and WHO encourage ethical partner counselling programmes which employ serious counselling and persuasion towards counselling of partners
- Where **a client refuses to notify his/her partner of their HIV infection** public health legislation should authorise, but not require, that health care professionals decide whether to inform their client's sexual partners of the status of their patient. This decision should be on the basis of each individual case and ethical considerations. **Such a decision should only be made in accordance with the following criteria:**

  - The HIV-infected person has been thoroughly counselled
  - Counselling of the HIV-infected person has failed to achieve appropriate behaviour changes
  - The HIV-infected person has refused to notify, or consent to the notification of his/her partner(s)
  - A real risk of HIV-transmission risk to partner(s) exists through current/future sex with partner, sharing of needles, etc.
  - The identity of the HIV-infected person is concealed from the partner(s) if this is possible
  - Follow-up is provided to ensure support to those involved, as necessary

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Module 2

Sub module 7: Suicide risk assessment in HIV and management strategies

Session objectives

At the end of the training session, trainees will be able to:

- Dispel some of the myths about suicide
- Understand some of the reasons for suicide
- Know the classifications of suicide methods
- Conduct a suicide risk assessment
- Appreciate the referral indications for suicidal clients
- Appreciate the counselling issues in suicidal clients
- Apply effective management strategies for counselling of a suicidal client

Time to complete sub module

3 hours 30 minutes

Training materials

- PowerPoint presentation **(PPT17)**
- Activity sheet **(AS17 & AS18** case studies**)**
- Handout **(HO16)**
- Question box
- Evaluation form collection box

Session instructions[i]

1. Commence the PowerPoint presentation **(PPT17).**
2. Group activity:
   - Present each myth one by one asking the group members about their responses. Engage the members in disputing the myths with examples. Refer the trainees to the suicide myths section of their handouts **(HO16)**
3. Continue the PowerPoint presentation.
4. *Activity:*
   - Refer the trainees to **AS17** - Section A: Suicidal risk assessment guideline. This is also included in the handout **(HO16)**
   - Review the questions in the suicidal risk assessment guideline. Emphasise the importance of

[i] Due to the strong emotions this sub module can elicit it is suggested that this sub module is conducted over 2 sessions with a substantial break in between.

the use of counselling microskills to convey concern, empathy and calm support to clients
- Pair up the trainees and ask them to practise a risk assessment for 20 minutes as a role-play
- Hand out the suicide risk assessment cases **(AS18)** to the "clients" only
- "Counsellors" are to be instructed to introduce themselves by saying that they are a counsellor and that "you have been asked to see me because people who care about you are worried about you." The counsellor should then proceed with conducting a suicide risk assessment
- Instruct the "clients" to provide feedback to the "counsellors". The "counsellors" should be encouraged to discuss what they felt they could have done differently and also their emotional response to the role-play
- After the debriefing has occurred ask the trainees to switch roles

5. Review the session with the group. Ask the trainees what they experienced during their role- plays.
6. Ask the trainees to come up with key points for counsellors to remember when conducting a suicide risk assessment.
7. After a break re-commence PowerPoint presentation **(PPT17)** which addresses determining high risk and low risk levels.
8. *Activity:*
   - Refer the trainees to **AS17** – Part B: 'At-a-glance risk determination' and Part C: 'Suicide risk assessment matrix' (this is also included in their handout **HO16)**
   - Ask them to divide into two groups to discuss their respective case studies (i.e. one group for case study 1; one group for case study 2)
   - Ask them to discuss the features of the case study which characterise them as high or low risk and to decide the risk level of their case study. Ask them to base their discussion on the 'at a glance risk determination' and the suicide risk assessment matrix
   - After their discussion, invite the trainees to come together as one group and discuss their determinations for the two case studies
9. Finish the PowerPoint presentation **(PPT17)** which addresses suicide management strategies.
10. Congratulate the group on their work and remind them that this topic can elicit strong responses.
11. Refer the trainees to the handout **(HO16)** and mention that there is additional recommended reading at the end of the handout on crisis counselling.
12. Ask the group if they have any questions and remind them about the "question box".
13. Ask the trainees to complete an evaluation form for the sub module and place it in the evaluation form collection box.

Case study 1

A female, 30-years-old, is attending a pre-test counselling session. She is a nurse at the local health centre. She has two young children and is excitable by nature. She is attending the service because she has been informed by her husband that he is HIV positive. She is very worried about the result and says during the pre-test counselling session that she will kill herself if she finds out she is HIV positive. Since she found out that her husband was HIV positive she has already made one suicide attempt by taking a non-lethal dose of pills. After taking the pills she called her mother for help.

She said that she is worried about who will look after the children. But since her suicide attempt her family has been very supportive. She still works every day and she says that this helps take her mind off such thoughts. She says working at the health centre has given her an opportunity to know about the services available in the community to help people and families who are affected by HIV.

Case study 2

This is a case of a young male, 20-years-old. A month ago he attended the VCT service and found out that he was HIV positive. A person who he met through a peer support group persuaded him to attend the current service as in one of the peer group sessions he had talked at length about his plan for suicide. In fact, he has threatened to put his plan into action this very afternoon. The person who brought him in says it was hard to convince him to come to the service and it was also difficult to follow what he was saying. The young man has not been seeing his family or friends since he discovered he is HIV positive. His family relations have been very strained over the past year since the family members found out he was injecting drugs.

He confides to the counsellor that he is disappointed that his suicide attempt last week did not work. He feels he is a burden even on his peer support group. Suicide is all he can think about and feels there is nothing else he can do.

Module 2

Sub module 7: Suicide risk assessment in HIV and management strategies

Session objectives

At the end of the training session, participants will be able to:

- Understand some of the reasons for suicide
- Know the classifications of suicide methods
- Conduct a suicide risk assessment
- Appreciate the referral indications for suicidal clients
- Appreciate the counselling issues in suicidal clients
- Apply effective management strategies for counselling of a suicidal client

1. Introduction

Suicide is the act of killing oneself.
Para-suicide is the suicide attempt.
Suicide ideation is the thought of killing oneself.

The suicidal act itself is the communication that there is a problem that needs resolution. Death may be seen as a way out of difficult circumstances. Frequently, people who feel miserable and think of suicide will share that feeling with someone. They are often amenable to intervention and eventually find alternative means to structure their lives although this process may be interrupted by cries for help.[1] The belief that people who threaten to kill themselves ***never*** do so is wrong!!

All suicide threats should be taken very seriously.

2. Common myths

- People who think or plan to commit suicide keep their thoughts to themselves, and the suicide occurs without warning.
- Those who talk about suicide won't do it.
- People who talk about suicide are just seeking attention.
- Suicidal people are intent on dying.
- Talking openly about suicide may cause a suicidal person to end their life.
- All suicidal people are crazy. It's the act of a mentally ill or psychotic person.

3. Suicide risk in HIV

There are two periods when people with HIV are more likely to attempt suicide. The first is when the person is initially diagnosed and suicide may occur as an impulsive response to the emotional turmoil

that follows[2]. The second period of high risk occurs late in the course of the disease when the central nervous system complications of AIDS develop. The capacity to earn income declines and people feel they are a burden for family members and carers.[3] During late stage of the disease, people experience adjustment issues associated with this stage of the disease, impairment of thinking, and possible complications of underlying changes in brain chemistry.[4]

Other factors which may contribute to suicide risk are:

- A pre-existing mood disorder (depression, anxiety or mania)
- A current psychiatric disorder such as schizophrenia or bipolar disorder
- Presence of other psychosocial stressors, e.g. relationship breakdown
- Substance use or withdrawal
- Inadequate pre- and post- test counselling
- Inadequate support network
- Discomfort with sexuality and/or gender

4. Classification of suicide methods

a) Violent methods: This is when the client uses or thinks of using violent means as a way of killing themselves, e.g. hanging, shooting, burning, planned accidents or jumping from heights.

b) Non-violent: When the client uses non-violent methods such as drug overdose, poisoning, exhaust fumes or suffocation.

c) Passive methods: Suicide can also occur in a passive form as patients choose to die by refusing to accept treatment. This can be distressing for carers and raises many ethical considerations. Whilst this may be considered an informed and reasonable decision on part of the individual it also may reflect an underlying masked mood, inappropriate guilt or a response to poor palliative care.

5. Suicidal risk assessment

A good assessment interview is part of the therapy. It is often enough to change suicidal thoughts. In most cases, the client comes in at a point of great personal crisis and requires urgent attention. They may be accompanied by a relative. The counsellor should see him/her alone first. This is because many para, suicidal clients feel powerless and often unwilling to be frank and open about their problems in front of others.

When a counsellor is dealing with a para-suicide, it is important to first clear the client medically. Always check whether s/he has taken anything poisonous before beginning counselling. Do not be too quick to sit down and counsel when in fact the client could have taken some poison and could collapse during the session.

6. Hopelessness

Suicide ideation and attempted suicide are closely related to feelings of hopelessness. It will be important to determine the individual's thoughts about the future and his or her beliefs about improvement of current circumstances. If the individual believes that positive change is unlikely, the counsellor can try to restore hope by reassuring the individual that everything possible will be done to help and by teaching the structured problem-solving method. The counsellor will also need to be on the lookout for other symptoms that may suggest the presence of clinical depression. Specialist referral may be necessary.

7. Suicidal risk assessment guideline[5]

This is not a questionnaire in the usual sense. These are guidelines for helping professionals on how to interview persons-at-risk of suicide. As guidelines rather than a ready-to-use questionnaire, many questions would need more exploration and probing in order to preserve the subjective reality of each individual-at-risk.

1. Do you sometimes feel so bad/hopeless/helpless you think about suicide? YES /NO

Follow this up with the following explorations:

2. How often?
   a. Are you currently thinking of suicide? YES /NO
   b. Have you thought how would you do it? YES /NO
3. Do you have a plan? YES /NO
   a. How lethal is the planned method?
      EXPLORE the perception of the person at risk!
4. Do you have the means? EXPLORE
5. Have you decided when you would do it? EXPLORE
6. Have you ever tried suicide before? EXPLORE

If 'yes' check whether previous attempt was:
   a. Impulsive
   b. Planned
   c. Carried out using any 'booster' such as alcohol/drugs

7. If you have tried suicide before, what difference, if any, did it make?
   Write down the client's answer. Generally any positive change perceived by the client makes the risk higher.
8. Check for symptoms of clinical depression. EXPLORE
   a. Neuro-vegetative symptoms:
      - Sleep
      - Appetite
      - Tiredness/lack of energy
      - Agitation/slowing down
      - Sex

   b. Mood and motivation
      - Prolonged unhappiness
      - Loss of interest or pleasure
      - Hopeless
      - Helpless
      - Difficulties performing at work
      - Difficulties carrying out routine activities
      - Withdrawal from friends and social activities
      - **Check for somatisation** (pains, aches, physical discomfort without any organic cause)

8. Exploring the problem

- Why do you think of suicide now? (what are the current difficulties/problems)
- What are you doing about your problem? (current coping)
- How did you deal with problems in the past? (ask for examples)
- What can be the possible reason that it does not work now?
- When did your problem(s) start?
- Who is affected by your problem?
- How does it affect you?
- What makes it better or worse?
- How can you be helped?
- Who would you like to know/not know about your problem?

9. What do you need in order to stay alive?

- What changes would help you stay alive?
- What do you have to do to make the change(s) possible?
- What barrier(s) to change exist?
- What can facilitate the process of change?
- Whose help/assistance would you need?
- What are your current needs?
- How do you care for yourself?
- What can possibly happen to make you change your mind?
- What if it happens?

10. Problem solving plan

- Define the problem
- Brainstorm the options
- Analyse the options
- Chose one option and divide it into steps to follow

11. Assessing risk level

The counsellor should explore and assess whether the risk of suicide is high or low. A detailed risk assessment summary is included at the end of this document. This tool can be completed by the counsellor whilst the client is present or whilst the counsellor writes their records. Assessing the risk level is essential as it will determine the next steps the counsellor should take.[6]

12. Referral indications

Little emotion, an "already dead" feeling, is the most dangerous sign. Often this client is frank about the intention to kill himself/herself eventually, but sometimes they will deny this in order to be released from the VCT centre. Some clients have a total denial of anger, and in most cases these clients have a history of being abused in childhood. These clients need to be referred to a psychotherapist, clinical psychologist, psychiatrist, etc. if one is available. Other clients may need referral to specific helping agencies, e.g. legal aid, welfare organisations supporting unmarried mothers, single parents, etc.

Review the case that you used for the suicide risk assessment. Using the detailed assessment guide decide whether the client is high risk for suicide or low risk (Table 1 and Table 2 on page 169).

Table 1: **An at a glance risk determination**

High risk	Low risk
1. Current suicidal thoughts	1. Only one attempt, less lethal means used
2. Client reports feeling of hopelessness	2. Client expresses some feelings of hope
3. Use of maladaptive coping strategies	3. Client has well developed coping responses to past crises
4. Multiple attempts, lethal means used	4. The client gives a valid reason for not wanting to repeat the experience, e.g. the pain made her realise that death was not the answer
5. The attempt was made when others were not present	5. Single attempt, which was made impulsively
6. The client says he/she will try again	6. Someone else was informed immediately
7. The client says he/she won't try again but can't give a good reason for what is now different	7. Client indicates s/he has mixed feelings about suicide. Can provide a good reason why they may not commit suicide, e.g. against their religion, will upset the family
8. Declining health and limited treatment options	8. Client may express concern s/he is a burden but feels suicide would place a greater burden on others
9. Client feels s/he is a burden	

13. Next steps for counselling the management of suicidal clients[7]

This is determined by whether the client is at the pre- or post- attempt stage, although these have some similarities. ***Always assess the risk in both stages.***

14. Key points for counsellors assessing and managing suicide

Pre-attempt stage

- Determine the severity of the problem and check for the need to hospitalise client
- Negotiate for voluntary hospitalisation or refer to the client's doctor
- Do not leave a suicidal person alone while arrangements are being made for referral
- Help develop alternative coping mechanism and decrease stress
- Mobilise support system for client
- Initiate (verbally or in writing) a no-suicide contract to ensure the short term safety of the client

15. Next steps for high suicide risk individuals:

1. **Ensure appropriate supervision or hospitalisation for the individual.** Do not leave the individual alone for any length of time. Refer to a psychiatrist or mental health specialist

2. Family and friends may be able to provide suitable supervision

16. Next steps for lower suicidal risk individuals:

1. **Ensure the individual has immediate 24-hour access to suitable clinical care** (e.g. crisis team, extended hours team, general practitioner, hospital, telephone support). Give the individual a list of contact numbers and provide explicit contingency plans if one or more of the contacts is unavailable. The client may become suicidal again so these are important considerations

2. **Remove all means of committing suicide.**e.g. guns, pills, chemicals, car (take the keys), knives, rope, other weapons. If the individual requires medication, ensure he or she only has access to a very small amount. Encourage the client to do this and ask family or a friend to supervise

3. **Make a suicidal contract - to delay the individual's suicidal impulses.** For example, make a "contract" with the individual in which he or she promises not to attempt suicide within an arranged (short) period of time. Also, provide other options for the individual to use at times when he or she is on the verge of attempting suicide (e.g. suggest that the individual calls someone reliable for help, such as yourself, a trusted family member or friend, a doctor, or a crisis hotline)

4. **Restore hope.** Encourage the view that all problems can be solved. Identify, explore and validate the client's ability to cope with past crises or difficulties. Use a structured problem-solving method as an important skill for the individual to learn

5. **Environmental intervention.** Encourage the client's active participation in the current situation

   Involve family members in caring for the individual and in structured problem solving. Encourage a supportive network away from the counsellor (e.g. family, friends, and agencies). Encourage the use of community resources (e.g. crisis hotlines, police, medical centres).

   Refer to services as appropriate.

   Help the individual to resolve any immediate conflicts with others that are contributing to the problem. Help the individual to structure time in between therapy sessions and ensure sessions are frequent, regular, and planned in advance

6. **Always conduct a follow-up assessment.**

17. Special problems counsellors may encounter with clients

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

18. Individuals who refuse to talk

An individual may refuse to discuss their previous suicide attempt or current thoughts or plans because:

- They may be afraid that they will be prevented from committing suicide
- They may be embarrassed or ashamed about having the suicidal thoughts or about their previous suicide attempt/s
- They may be afraid of being labelled "mentally ill"
- They may be afraid that they will be sent to hospital
- They may doubt the confidentiality of the interview
- They may be oppositional or manipulative

Naturally, the individual is correct to believe that he or she may be prevented from committing suicide. Furthermore, the issue of confidentiality will be overridden to some extent in situations in which the counsellor believes the individual is acutely suicidal. If it is felt that the individual is at a high risk of self-harm and will not accept help, it may be necessary to talk to a psychiatrist or general practitioner about the possibility of scheduling the individual under the Mental Health Act.

With regard to the other reasons for refusing to talk, the clinician can reassure the individual about his or her willingness to help and about the extent of confidentiality of the interview. A non-judgemental manner will be extremely important. If the individual maintains a reluctance to talk it will be helpful to ensure that s/he knows how to contact a clinician at any time of the day in case s/he changes his or her mind. A follow-up letter to the individual reminding him or her of the offer of help may also be useful.

19. Individuals who make repeated suicide attempts

These individuals usually feel lonely and isolated and may be trying to get attention. Alternatively, they may be threatening or attempting suicide for the purpose of being manipulative. Others may simply lack more appropriate coping techniques. However, regardless of the individual's reason for attempting suicide, all attempts need to be taken seriously. It is important for counsellors to remember that individuals are in distress and that they may lack more appropriate ways of coping with their emotions.

20. Personality disorders and frequent suicide attempts

Crisis management

Although it is important to establish and follow a clearly defined management plan, despite the best of intentions there will be times when other crises will inevitably interfere with this plan. In some cases involving "para-suicidal, borderline" individuals, certain behaviours or "crises" may need to take precedence over the ongoing management plan or other goals that the clinician and individual have agreed to work on. These behaviours are hierarchically ordered by importance as follows:

1. Suicide threats, suicide attempts and other life-threatening behaviours

2. Behaviours that interfere with the process of treatment (e.g. missing sessions, being overly demanding, angry outbursts, repeated admissions to hospital)

3. Behaviours that seriously interfere with the individual's quality of life (e.g. substance abuse, antisocial behaviours)

Suicidal threats, gestures or attempts

The rate of suicide completion for individuals with this personality type, although lower than those with schizophrenia and affective disorder, is substantial and thus all suicide attempts need to be taken seriously even if they appear manipulative and unlikely to have been lethal. As suggested above, the first target of management will always be high risk suicidal behaviours. It has been argued that one of the best predictors of suicidal behaviour is the occurrence of previous suicide attempts. There is some suggestion that problems in interpersonal relationships, depression and substance abuse are also risk factors in this population.

Suicidal threats and ideation need to be immediately and actively assessed. Once the individual's safety is assured, the goal of any intervention will be the replacement of suicidal behaviours with more

adaptive ways of solving problems. As with all suicidal behaviour, if the suicide attempt appears to be an inappropriate method of solving a problem (rather than being solely an attempt to manipulate others or gain attention), then a structured problem solving approach will be very helpful. There are now a number of studies to suggest that problem solving is effective for decreasing further suicidal behaviour in individuals who repeatedly attempt suicide.

There are a number of advantages in targeting suicidal behaviour as a priority for management. First, making suicidal behaviour a management priority reduces the likelihood of future suicidal behaviour. Secondly, it communicates that the clinician takes such behaviour very seriously. Thirdly, the individuals themselves soon learn that if they engage in such behaviour, they will spend their time with the clinician discussing this behaviour and applying the problem-solving model rather than being able to spend time on other topics. Fortunately, suicide completion in these individuals becomes less likely as they get older.

21. Medical complications following an unsuccessful attempt

Following a suicide attempt, the individual's physical health will need to be closely monitored by a doctor. However, all clinicians need to be aware that some of the seemingly "less" harmful methods may actually cause serious complications. For example, an overdose of paracetamol may lead to liver failure and subsequent death. Unfortunately, some individuals who overdose on paracetamol are less serious about dying and are seeking help and attention. Deaths among these individuals are especially tragic.

22. Alcohol consumption

Many individuals who attempt suicide have drinking problems. These individuals may also be very reluctant to admit that this is true. Research by Mayfield and colleagues using a psychiatric population indicates that four simple questions can be used to identify a large proportion of individuals who have alcohol problems. Although this screening instrument is by no means entirely reliable, positive responses to two or more of the questions below were found to correctly identify 81% of problem drinkers while misclassifying only 11% of non-problem drinkers. The accuracy of identifying alcohol abusers is increased if individuals with psychosis and organic brain disease are excluded.

If two or more positive responses are given it will be important to discuss alcohol use with the individual and possibly refer him or her to a suitable drug and alcohol programme if appropriate.

The CAGE Questionnaire: Alcoholism screening instrument

1. Have you ever felt that you should **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticising your drinking?
3. Have you ever felt bad or **G**uilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?

23. Antidepressants

Antidepressants usually only start to lift depressive mood symptoms after a lapse of up to two weeks or more. However, the psychomotor retardation that is often associated with depression tends to lift prior to improvement of mood.

Consequently, there is a period of time during which the individual is severely depressed but has a higher activity level. It is frequently during this period that many individuals attempt suicide. Hence, if the individual has just been started on antidepressants and is being managed in the community it is important for the individual's family or carers to keep a close watch on the individual and to avoid leaving him or her unattended during this critical phase of management. It is also important that the individual is aware of the antidepressant time lag. At first, the individual may only notice side effects. It may be useful to explain to the individual that these side effects indicate that the medication is beginning to work.

24. Some questions used to probe for suicidal thoughts

Whenever a client is angry or depressed the counsellor should find out whether she/he is contemplating suicide. Don't be afraid of putting ideas into his/her head; they are probably there already and your asking won't make any difference.

- Do you sometimes feel it's not worth staying alive?
- Do you ever think of killing yourself? (if the answer to above question was yes)
- How would you do it? (if the above answer is yes)
- Have you ever tried to kill yourself?
- What happened on that occasion? (etc.)

Many suicide attempts are made in the context of a family row. Para-suicide is more often connected with anger and perceived powerlessness than with depression. The angry client must be challenged to think of new ways to vent his/her anger. If any client claims never to become angry, you know that anger seems so dangerous to him/her that he/she refuses to recognise it. There is no human being who never becomes angry.

Dealing with denied anger is a different task and therefore an indication for referral.

If the client says, *"I will just have to control myself in future,"* or *"I won't get angry anymore,"* they are not thinking realistically. Demand that they keep thinking until they generate practical solutions.

It might also be important to increase the client's power in the specific relationship, which created the context for the suicide attempt. Explore their support systems — are there family members or friends in whom they could confide? Do any of them have the power to influence the issue they are afraid of? Suicidal behaviours and management should be based on the view of suicide as a response to a crisis situation, hence relief of client's intense emotional suffering is paramount until they regain adequate coping skills and resume full responsibility for their lives.

25. Post-attempt stage

- Clear the client medically
- Check or assess the level of the risk
- Explore for future plans (i.e. for problem solving and reasons for staying alive).

Crisis intervention strategies take centrestage initially to remove the client from danger, and long-term counselling is needed to address the issues underlying the attempt.

Additional suggested reading on crisis counselling[8]

Definition of a crisis: There are various definitions of a crisis including:

- A crisis is an acute disorganisation or a disruption in functioning of the individual due to external or internal stress
- A crisis is the experience of being confronted with an unfamiliar obstacle in life's path
- "When an individual experiences heightened stress that is prolonged or perceived as extremely severe, they may feel that their coping resources are inadequate to meet the adjustive demands being made on them. In such circumstances they are in a situation of excessive stress or in a state of crisis"[9]

An emotional crisis occurs:

- When an individual feels intensely threatened
- When he/she is completely surprised and caught unawares by whatever is happening
- As a result of loss of control
- When there does not seem to be any solution to the problem and when all efforts to resolve the crisis seem hopeless

Categories of crisis:

- Developmental crisis
- Accidental/situational crisis
- Existential crisis

Conditions when a crisis may occur:

- It may develop due to an external factor (e.g. loss).
- It may be due to an internal distress.
- It may be due to a transitional stress that demands adaptive responses.

Stress factors that may contribute to a crisis:

- Relationships, marriage and family (e.g. conflict, death, children, sexual difficulties, separation/ divorce)
- Occupational, work-related (e.g. unemployment, changing jobs, overwork, retirement)
- Educational, study, school (e.g. exams, public speaking difficulties)
- Adverse social conditions (e.g. poverty, poor housing, lack of community support)
- Intrapersonal (e.g. depression, loss of meaning of life, feelings of guilt, irrational thinking)
- Body harm (e.g. violence, terminal illness, rape, disability)[10]

"There are therefore numerous situations which may cause clients to feel that they are at the limit of their coping resources, though there are wide differences in people's ability to tolerate these various stress factors. Resilience in the face of stress depends partly on personal resources. However, it may also be heavily influenced by the amount of family, social and community support available."[11]

Possible reactions to a crisis[12]:

Body: Body reactions may include hypertension and tendency for heart attacks, gastric or duodenal ulcers, etc. The weakest parts of different clients' bodies tend to be most adversely affected by stress.

Feelings: The feelings associated with excessive stress may include shock, depression, frustration, anger, anxiety, disorientation and fear of insanity or nervous breakdown.

Table 2: **Suicide Risk Assessment Matrix**

Name:_____ Date:_____/_____/_____ Counsellor:_____

Details	Lower risk	Medium risk	High risk
Score 1			
1. Suicide plan			
a. Details	• Vague	• Some specifics	• Well thought out; knows when, where, how
b. Availability	• Not available, will have to get	• Available, has close by	• Has in hand
c. Time	• No specific time or in time	• Within a few hours	• Immediately
d. Lethality or method	• Pills, slash wrists	• Drugs and alcohol, car wreck, carbon monoxide	• Gun, hanging, jumping • No one nearby; isolated
e. Chance of intervention	• Others present most of the time	• Others available if called upon	
2. Previous suicide attempts	• None or one of low lethality	• Multiple, of low lethality or one of medium lethality, history of repeated threats	• One of high lethality or multiple of moderate lethality· • Several attempts over past weeks
3. Stress	• No significant stress	• Moderate reaction to loss and environmental changes	• Severe reaction to loss or environmental changes • Many recent social/personal crises
4. Symptoms			
a. Coping behaviour b. Depression	• Occasional suicidal thoughts • Daily activities continue as usual with little change • Mild, feels slightly down	• More than one suicidal thought per day • Some daily activities disrupted, disturbance in eating, sleeping, schoolwork • Moderate, some moodiness, sadness, irritability, loneliness and decrease of energy	• May resist help· Constant suicidal thoughts • Gross disturbances in daily functioning • Disillusions, paranoid, lost touch with reality • Overwhelmed with hopelessness, sadness and anger (verbal/physical) feelings of worthlessness • Extreme mood changes

	Details	Lower risk	Medium risk	High risk
5.	**Resources**	• Help available; significant other/s concerned and willing to help	• Family and friends available but unwilling to help consistently	• Family and friends unwilling or hostile, exhausted or injurious • Significant self-neglect
6.	**Communication aspects**	• Direct expression of feelings and suicidal thoughts	• Interpersonalised suicidal goal ("they'll be sorry –I'll show them")	• Very indirect or non-verbal expression of internalised suicidal goal (guilt, worthlessness)
7.	**Lifestyle**	• Stable relationships, personality and school performance	• Recent acting-out behaviour and substance abuse, acute suicidal behaviour in stable personality	• Suicidal behaviour in unstable personality, emotional disturbance, repeated difficulty with peers, family and teachers
8.	**Medical Status**	• No significant medical problem	• Health declining	• Chronic debilitating illness, significant weight loss
Total				

Thoughts: Some of the main thoughts associated with excessive stress are that clients are powerless to make a positive impact on their situations, that things are getting out of control, and despair or lack of hope for the future. Thought processes can be somewhat irrational. Clients may think with 'tunnel vision', which involves focusing on only a few factors in a situation.

Actions: Avoidance and overactivity are two of the main ways in which clients handle excessive stress. Avoidance behaviour may range from giving up to not making efforts towards dealing with their problems. Violence, either turned outwards or inwards, is more possible at times of excessive stress than when clients' stress levels are lower.

Phases of a crisis:
1. Blow or the impact (reaction)
2. Recoil
3. Withdrawal
4. Acceptance and adaptation

Features of a crisis:
- Generally self-limiting
- Often resolves within a period of 1 to 4 weeks
- The client may desire to be helped by others, and is more amenable to outside intervention.

The outcome of a crisis depends on:
- The individual himself/herself
- Society, culture and environment
- Matters of chance, random happening

Principles of crisis counselling:
- It should be brief
- It is directive — it requires the therapist to take an active, direct role with clients
- It deals with the individual, families and social networks
- It focuses on the client's present problems
- It is reality-oriented — it enables the client to have a clear cognitive perception of the situation
- It helps the client in developing more adaptive mechanisms for coping with future problems and crisis

Some basic guidelines for crisis management[13]:
- *Be prepared* – network with other services and health care workers and establish a good referral network
- *Act calmly* – to help the client calm their heightened emotions, the counsellor themselves need to remain calm. Responding in a warm yet firm and structured manner will give the client security in your ability to assist them
- *Listen and observe* – this can ease a client's despair and help them feel heard and accepted
- *Assess severity of disturbance and risk of damage to self or to others* – suicide risk assessment is crucial for someone in crisis. Avoidance of the topic may increase rather then diminish the risk
- *Assess client's strengths and coping capacities* – in a state of crisis clients often need assistance to explore their resources for coping
- *Assist exploration and clarification of problem(s)* – due to intense feelings, clients in crisis have often lost perspective on themselves and their problems. Use empathy, open questions, and summarising skills to help define the factors generating the intense feelings

- *Assist problem-solving and planning* – this aids clients to regain a sense of control over their lives. Identify strategies to address the issues of concern and mobilise additional resources as required.
- *Be specific about your own availability* – offer further appointments as required and establish with the client an emergency plan should they need assistance between appointments.

A detailed structure for the management of crises is provided below in terms of the stages of counselling that a counsellor may follow in dealing with a client in crisis.

Stages of crisis counselling:

Stage 1: Delineating the problem focus:
- Rapport building
- Identifying stress/crisis/trauma
- If there is no identifiable crisis, review client's life changes/events, history or look for a contributory factor.

Stage 2: Evaluation
- Demographic data
- Client's psychosocial and medical history
- Psychological functioning
- Pre-crisis adjustment

Stage 3: Contracting
- Clearly state the problem
- Set time limits
- Inclusion of others
- Specify client's responsibilities

Stage 4: Intervening
- Listening
- Utilising interpersonal resources
- Utilising institutional resources
- Advocacy
- Confrontation
- Giving information
- Exploring other coping mechanisms
- Advice and suggestions
- Behavioural task assignments

Stage 5: Termination
- Prepare client for termination
- Manage problems of premature termination

Stage 6: Follow-up
- For evaluative, educative and clinical purposes

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