GUIDELINES AND STANDARDS FOR COUNSELING

HIGH-RISK GROUPS IN CLINIC SETTINGS

FAMILY HEALTH INTERNATIONAL

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fhi Family Health International

Family Health International

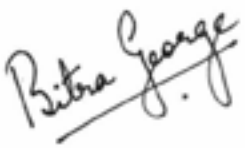
India Country Office
16, Sunder Nagar
New Delhi 110 003, India
Tel :(91 11) 4304 8888
fax :(91 11) 2435 8366
www.fhi.org

Foreword

The India AIDS Initiative (Avahan) of the Bill & Melinda Gates Foundation (BMGF) aims to bring effective HIV prevention services to an estimated 200,000 female sex workers, 60,000 high-risk men who have sex with men, and 20,000 injecting drug users in India's six highest HIV prevalence states. Additional interventions target clients of sex workers including high-risk men along the national highways. Avahan works through state- and local-level nongovernmental organizations (NGOs) and community-based organizations (CBOs) to provide peer-led outreach education and facilitate community mobilization, commodity distribution such as free condoms for sex workers, and clinical services for high-risk groups. Since 2007, 412 clinics are operational with project support.

Family Health International (FHI) has been providing support to the National AIDS Control Organization (NACO), State AIDS Control Societies (SACs), and Avahan state lead partners (SLPs) in implementing quality STI services through the STI capacity raising grant from BMGF. In addition, FHI has provided quality technical assistance to SLPs to implement primary HIV care and support services and strengthen linkages to the Revised National Tuberculosis Control Program (RNTCP). It is well established that health education and counseling is an integral component of STI services. This document, *Guidelines and Standards for Counseling High-risk Groups in Clinic Settings*, defines the guidelines and minimum standards for counseling services provided in Avahan-supported clinics. The document focuses on STI counseling; if the clinic has an on-site integrated counseling and testing center (ICTC) the counselor should receive additional training using the National AIDS Control Organization *HIV Counseling Training Module 2006*, available at www.nacoonline.org/Quick_Links/Publication/Basic_Services.

This document was developed by FHI/India staff in collaboration with Nancy Jamieson, former senior technical officer for behavior change communication, Asia Pacific Regional Office, FHI. The counseling guide was also reviewed by Gloria Sangiwa, former senior technical advisor, FHI/Arlington. FHI acknowledges the contributions from the staff of YR Gaitonde Center for AIDS Research and Education, Chennai, and useful inputs from the SLPs and clinic counselors during the development of this document. We hope this manual will be useful in guiding Avahan clinic staff, NGOs, and CBOs implementing targeted interventions on how to provide quality counseling services for high-risk group members.



Bitra George
Country Director
Family Health International/India

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Acronyms

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
BCC	Behavior change communication
CBO	Community-based organization
COGS	*Clinic Operational Guidelines and Standards*
FSW	Female sex worker
HIV	Human immunodeficiency virus
HRG	High-risk groups. In Avahan, this refers to SW, MSM, TG, and in some cases, IDU populations.
HRGF	Key population facilitators
ICTC	Integrated counseling and testing center
IDU	Injecting drug user
IEC	Information, education, communication
IUD	Intrauterine device
MSM	Men who have sex with men
MSW	Male sex worker
NACO	National AIDS Control Organization
NGO	Nongovernmental organization
ORW	Outreach worker
PE	Peer educator
PF	Peer facilitator
PMTCT	Prevention of mother-to-child transmission.
	Sometimes PPTCT is used: prevention of parent-to-child transmission.
RPR	Rapid plasma reagin
SACs	State AIDS Control Societies
SLP	State-led partner
STI	Sexually transmitted infection/s
SW	Sex worker
TG	Transgender (Aravani/Hijra)
VCT	Voluntary (HIV) counseling and testing

INTRODUCTION

The goal of the Avahan India AIDS Initiative is to enable individuals and communities to gain control over their lives and improve their health by encouraging and enabling positive sexual health choices. The Avahan project provides both clinic- and community-based services to support achievement of this goal.

Effective STI control among vulnerable key populations is an important strategy to reduce HIV transmission. Avahan STI services are described in the *Clinic Operational Guidelines and Standards* (COGS).[1] The *Guidelines and Standards for Counseling High-Risk Groups in Clinic Settings* supplement the COGS and the *National AIDS Control Organization (NACO) HIV Counseling Guidelines* to ensure quality STI counseling in Avahan-supported clinics[2] and in clinic outreach activities provided in the community. Counselors can refer to the COGS for more detailed information on STI clinic operations, structures, and services.

Counseling is identified as an essential component of STI services in the COGS:

> "Counseling is a process in which clients learn how to make decisions and formulate new ways of behaving, feeling, and thinking. Counselors focus on the goals their clients wish to achieve. Clients explore their present levels of functioning and the changes that must be made to achieve personal objectives. Thus, counseling involves both choice and change, evolving through distinct stages such as exploration, goal setting, and action."[3]

STI counseling focuses on both STI and HIV prevention and on ensuring that clients are able to benefit fully from the clinical STI treatment provided. The goal of counseling in the clinics is to help HRG clients[4] make positive decisions regarding their sexual health or behaviors that increase the risk of STI or HIV infection.

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1 *Clinic Operational Guidelines and Standards (COGS): Comprehensive STI Services for Sex Workers in Avahan-Supported Clinics in India.* Family Health International/Avahan. 2007.

2 This document does not provide comprehensive guidelines for HIV counseling. Programs intending to provide HIV counseling and testing should make use of the NACO ICTC guidelines and training curriculum.

3 http://www.counseling.org/Resources/ConsumersMedia.aspx?AGuid=97592202-75c2-4079-b854-2cd22c47be3f, The American Counseling Association, 1 January 2001.

4 In this document, "HRG" (key population) or "HRG client" is used to designate the Avahan clinic service users. In the COGS, the service users are referred to as "patients" to avoid confusion of service users with "clients" of sex workers.

Counseling is part of STI services because

- STI transmission is behavioral: that is, these are infections that are spread through human behaviors, sexual or drug injecting. Without changes, the person is likely to become infected again. HRG clients will need to have adequate motivation and skills to make appropriate changes in behavior.
- For STI prevention and treatment to be effective, clients will need to be motivated and able to complete treatment and to make sure that partners are also treated.

COUNSELING GUIDELINES AND CHECKLISTS: AN OVERVIEW

The STI counseling guidelines are intended to provide guidance and background information needed by STI counselors working in Avahan clinics. Each section in the main part of the counseling guidelines focuses on one topic of counseling. For many of the topics, there is additional information in an annex.

Counseling checklists for the different topics are also provided in the annexes. They list the main points or issues that need to be covered for each part of a specific counseling topic.

The checklists are meant as reminders for counselors. They may be kept on the desk for quick reference during a counseling session. They can also be used as a refresher before a session. The steps in the checklists are given in order, but counselors may decide to change the order, depending on how the counseling session flows.

The checklists may also be used by supervisors and counselors to review counseling sessions during supervisory sessions.

Neither the STI counseling guidelines nor checklists are meant as a substitute for basic counseling training and the continuing capacity building that is essential to assure quality of counseling.

Counseling Operations and Standards

SECTION ONE

Photo: Anita Khemka

Counseling services will be provided in the clinic and in outreach or community outreach settings. The process and content of any counseling session will depend on the setting, an HRG client's interest or needs, and the amount of time available for each counseling session.

1.1 BASIC MINIMUM COUNSELING STANDARDS

Avahan clinical facilities and services are to be available at times most suitable for their HRG clients. This may require opening in evenings. In the clinic, counseling will be provided in a room that has both auditory and visual privacy — that is, where the counseling cannot be seen or overheard by others. Each clinic will decide on the most appropriate use of counselor time and the client flow. Ideally, a counselor will spend a minimum of 30-40 minutes with a client on a first visit and 10-15 minutes for follow-up visits. However, the numbers of clients present at any given time or setting will determine the amount of time that can be spent with each client.

Counseling services may be provided in STI clinical facilities or in the community. Counselors will need to adapt the counseling service to fit with the time and facility available. For example, in outreach settings such as health camps or mobile clinics, it may not be possible to ensure auditory and visual privacy. Where this is true, counselors will explain this to clients and limit discussion to topics acceptable to the client. Counselors will encourage HRG clients to come to the clinic, where more privacy is possible.

The topics covered in any counseling session will depend on priority needs relating to the clinic visit. Wherever possible, health education may be provided by outreach workers (ORWs), peer educators (PEs), or peer facilitators (PFs) to individuals or groups, while the counselor focuses on more sensitive one-to-one counseling needs. Counselors will work closely with staff or volunteers who will be providing health education in conjunction with counseling.

Counselors will explain and maintain client confidentiality, making sure that all HRG clients understand that certain information will be shared with clinical staff to ensure appropriate care.

Delivery of Counseling Services

ADEQUATE TIME

Ideally the counselor will have adequate time with each client to

- build rapport
- cover and clarify relevant issues
- help client express feelings
- help client take in new information
- work on making decisions
- create a follow up plan

Most HRG clients will be coming for counseling linked to clinical visits. Time for each counseling session is often limited as most clients visit the clinic during the time doctors are present. Counselors will explain time limits to clients and encourage clients to return for additional counseling. They should also work with PEs/outreach teams to promote the benefits of counseling.

ACCEPTANCE

Counselors are expected to demonstrate respect and acceptance of all HRG clients, regardless of their lifestyles, sexual habits, and socio-economic, cultural, and religious backgrounds. Responses to clients' actions, feelings, and needs should not be affected by counselors' own feelings and values.

ACCESSIBILITY

The STI clinical facilities have been set up to be easy for HRG clients to reach, at hours that are best for them. STI services are also provided at temporary sites in communities. Counselors will be present whenever STI services are being provided.

QUALITY

- Counselors have adequate understanding of counseling objectives and processes.
- Counselors have adequate counseling skills.
- Counselors have an adequate knowledge base and make use of other expertise as needed.
- Counselors document counseling sessions and make use of a client's counseling record to ensure continuity of care, including counseling.

CONFIDENTIALITY

- Counselors explain and maintain shared confidentiality.

1.2 ROLES AND RESPONSIBILITIES OF COUNSELORS IN STI CLINICS

Roles of a Counselor

Counselors at Avahan STI clinics play a vital role in

- strengthening STI services provided by the clinic
- increasing uptake of services by HRG clients
- increasing follow-up of key populations
- establishing referrals and networking for expanded STI/HIV care and support

Responsibilities of a Counselor

Counselors are trained clinic staff. Their specific duties will be determined by each clinic.

Depending on the amount of time available and the priorities set, the counselor's responsibilities may include any of the following activities:

- reviewing client records prior to counseling sessions
- making sure an HRG client understands the purpose, process, and potential benefits of counseling

- taking and documenting health and sexual histories
- giving information about STI, its causes, routes of transmission, and preventive methods for symptomatic and asymptomatic HRG clients
- encouraging the HRG to raise doubts, providing correct answers in simple language
- motivating HRG clients to undergo internal examinations as part of STI care
- assisting HRG clients to correctly assess their risky practices and behavior in a nonjudgmental and supportive manner
- motivating and helping HRG clients to develop personal risk reduction plans according to their risk behavior and circumstances
- supporting the HRG clients' plans through skills teaching and practice
- motivating and supporting behavior change efforts of HRG clients through feedback and assisting with follow-up plans
- reviewing efforts and achievements relating to risk reduction plans on follow-up visits
- assisting HRG clients to develop STI treatment adherence plans
- motivating HRG clients who have been diagnosed with an STI to inform their partners, and to get them tested and treated if required
- helping HRG clients to prevent unwanted pregnancy and to access reproductive health services for themselves or a female partner
- making referrals for additional services that are not provided in the Avahan program
- motivating HRG clients to undergo periodic syphilis screening
- explaining and encouraging HIV testing
- assessing needs and making referrals for additional services
- providing counseling on pregnancy prevention or termination
- following up on previous counseling sessions
- establishing links between clinic services and outreach/PE services
- establishing links with other service providers, and with medical, legal, and social services
- obtaining and documenting client consent to share confidential information
- preparing and supervising ORW and PE who provide health education
- collaborating with clinical staff to ensure quality care
- documenting counseling sessions in the client record

Avahan clinics and programs will not be able to meet all client needs. Counselors are expected to be aware of the limitations of the program in which they work. They must be able to explain

these limitations and help HRG clients meet additional needs through referrals wherever possible.

Counselors must also be aware of the limitations of their own skills and make referrals for higher-level counseling when these services are available.

1.3 DISTINCTION BETWEEN COUNSELING AND HEALTH EDUCATION

Health education and counseling are both part of clinical case management. The focus of counseling has been described previously. Counselors may also provide health education to make sure an HRG client has the complete and correct information he or she needs to make decisions.

Often counselors will not have time to provide complete individual health education during a counseling session. Group health education is an efficient way to use the clients' time while they are waiting. This can be done effectively by trained PEs. A counselor should work with trained PEs to decide how to manage health education.

The clinic supervisor will need to ensure that collaboration between the counselor and the field teams is well planned and managed. The clinic supervisor will also be responsible for

TABLE 1: DISTINCTION BETWEEN COUNSELING AND HEALTH EDUCATION IN THE AVAHAN PROJECT

Counseling	Health Education
Confidential dialogue between counselor and each client, guided by client's needs	General information applicable to one or a group of HRG clients, not confidential
Usually a one-on-one process	Could be a one-on-one session but is usually for small or large groups of people
Processing of various emotions of the HRG	Emotionally neutral in nature, both for those who are being educated and for the health educator
Focused, specific, goal-oriented, solving the problems of the HRG being counseled	Giving information appropriate to the audience
Information used to change attitudes and motivate behavior change	Information used to increase knowledge and educate
Should be done by a trained counselor	Can be done by a trained ORW or PE

ensuring coordination between the counselor and clinical staff.

Health education may include the following topics:

- signs and symptoms of STI
- consequences of untreated or incompletely treated STI
- links between STI and HIV
- importance of taking medicine as directed
- how to prevent STI and reduce risk
- condom and lube teaching
- safer sex negotiation skill building
- rationale for partner treatment
- what happens during a physical examination and why it is done (speculum or anoscope examination)
- reasons for STI checkup/screening and asymptomatic treatment
- reasons for and process of syphilis screening and complete treatment for syphilis

1.4 COMMUNITY OUTREACH STI SERVICES

The Avahan Community Approach

Avahan clinics and programs are designed to promote and support active participation of the HRG communities. As described in the STI COGS, the participation is to be functional and meaningful. Capacity building will be provided to HRG clients to ensure effective participation.

Examples of meaningful participation are serving as members of clinic advisory committees or working in the clinics as a receptionist, peer counselor, health educator or, in some cases, with proper training, counselor. Ideally, participation will increase over time to include more involvement in day-to-day management decision making.

Clinic and community services are integrated. Clinic staff are expected to work closely with the project outreach team: that is, the staff and volunteers in the field, including peer educators (PEs), peer facilitators (PFs), outreach workers (ORWs), or other community volunteers.[5]

The PEs or PFs are responsible for motivating peers to come for clinic services. They may accompany them, at least on an initial visit. As PEs, PFs, and ORWs will be seeing HRG clients regularly in their community, they can also

- promote regular checkups and treatment
- remind when it is time to return for a checkup or follow-up on treatment
- organize specific days for checkups
- propose and negotiate sites for health camps or mobile clinics
- promote and gather HRG clients for health camps or mobile clinics

5 The Avahan project implementing partners make use of a variety of terms for the different cadres of community-level workers and volunteers.

- reinforce importance of taking medicines correctly and completing treatment
- assist with getting partner treated
- report any problems with STI treatment or counseling back to the clinic team
- provide health education in the clinic, during health camps, and at outreach clinics

PEs, PFs, and ORWs will also have other responsibilities that are assigned by their program/agency.

Outreach Clinics or Health Camps

Avahan clinics may use temporary sites to provide outreach or community-based clinical services. Outreach clinics may include

- clinics that are periodically set up in different sites in the HRG communities, often referred to as "health camps"
- mobile clinics, including services provided through vans that move from site to site according to a regular schedule (these are less common, as most programs do not have the type of vans needed)

Outreach clinics/health camps are a team effort. For example, the outreach team — that is, PEs, PFs, and ORWs — may identify locations and timings for outreach clinics and negotiate an agreement to "host" a clinic with a site manager/owner. The PEs/PFs inform and motivate HRG clients to attend the clinics. The clinic staff and outreach team work together to provide the services. Services may include referrals for follow-up in the clinic for care and counseling for issues that cannot be addressed in the outreach clinics. The outreach team will follow up with HRG clients as needed.

Health camps/outreach clinics can reduce stigma among the community and promote the use of STI clinic services by decreasing some of the barriers, such as distance, time, and fear of something unknown. An outreach clinic or health camp shows the HRG community that the project is willing to come to them. Counselors can use the opportunities provided by health camps to create a good rapport and relationship with the HRG clients and encourage them to come to the STI clinic.

Limitations of Counseling in Outreach Clinics

Time and privacy for personal counseling are often not available in outreach clinic settings. In these settings, group health education is an option, and even group risk assessment may be possible. Counselors will work with trained ORWs and/or PEs or PFs in keeping with the community-led approaches to STI management described in the COGS.

All clients seen in outreach clinics will be encouraged to come to the clinic for more personalized counseling. An appointment will be made if this is possible.

Home Visits

The counselor can make home visits at the request of the HRG client if this is in keeping with clinic policy. Home visits may be made to meet needs that cannot be addressed in the clinic or when the outreach team requests counseling assistance. Home counseling visits will be planned and coordinated with the appropriate outreach team members, who are likely to have greater insights into the situation and sensitivities of an HRG client. The outreach team member will help make an appointment that is acceptable to both the counselor and the client.

Counselors may find it best to make a home visit by going along with an ORW, PE, or PF who is well known to the HRG client, unless the counselor is experienced in making home visits. Confidentiality of the HRG client and personal safety of the counselor/staff must be the first considerations.

1.5 COUNSELING SUPPORT MATERIALS

Counselors will have appropriate information, education, and communication (IEC) materials to support counseling and for HRG clients to take away as reminders. These materials should be designed for each HRG and relevant to their needs. Materials must be appropriate to the literacy levels of clients. Copies of take-away materials should be kept in the waiting area or reception area of the STI clinic.

A supply of condoms and water-based lubricant will be available in the counseling room, along with a penis model for teaching condom use. The counselor should also have a speculum and an anoscope, along with large pictures of internal organs so that how and why these instruments are used can be explained while promoting internal examinations.

At a minimum, the following items are recommended to support effective counseling:

- counseling client record forms
- counseling guidelines with checklists
- pictorial IEC material to support counseling, such as material to explain STI issues and symptoms, family planning methods, the internal examination, and other related topics
- penis model, tissues, male and female condoms for demonstration
- water-based lubricants
- speculum and proctoscope/anoscope
- referral register and referral forms

1.6 COUNSELOR QUALIFICATIONS AND TRAINING

Qualifications and Preparation of Counselors in Avahan STI Clinics

The basic qualification requirement for counselors in Avahan clinics is a post-graduate

degree in social work, psychology, or sociology. In many circumstances, however, counselors with this level of training or education are not available. In these clinics, other staff will be recruited, trained, and supported to carry out the counseling responsibilities.

In keeping with the Avahan community participation model, ORW, PE, or another member of an HRG community may be hired as a counselor if he or she shows an ability and commitment and is acceptable to the HRG clients.

The acceptability of peer counselors will need to be assessed with the community to be served. Peer counselors are not always acceptable due to fears of breach of confidentiality or other sensitive issues.

STI Counselor Training

State lead partners (SLPs) of the Avahan project are responsible for training all clinic counselors on STI counseling based on these guidelines and for ensuring that appropriate refresher training is provided to all counselors. The SLPs are also responsible for making sure that ongoing technical supervision and support is provided to all counselors by a trained counselor/supervisor. The STI capacity building team (STI CB) will provide assistance to the SLPs for planning refresher training.

Regular Technical Updates

All professionals require continuing education if they are to deliver quality services. Each clinic/SLP should prepare a capacity building plan for staff. This plan may include organizing regular refresher training or updates, exchange visits, guest speakers, regular in-services, supportive supervision with constructive feedback, provision of appropriate reading material, and/or structured feedback from HRG clients. Counselors should be sent to trainings, conferences, and workshops where they meet colleagues and have an opportunity to share their work and challenges.

1.7 MONITORING, SUPERVISION, AND SUPPORT FOR COUNSELORS

The Avahan STI CB team, along with staff of the SLPs, will conduct quarterly visits to each clinic. During these visits, the team will review the counseling services and provide onsite mentoring support. The SLPs will appoint STI coordinators as well as selected counselors/counseling supervisors. These staff are to be trained to review the quality of counseling services and provide supportive supervision.

A regular quality monitoring system should be established using quality counseling indicators and standards, such as those provided in these STI counseling guidelines. Counselors are to be informed of both the

process and the content of any counseling quality review activities.

Additional information about supervision in the Avahan clinics is provided in Section 6.0: Counselor Supervision and Support.

1.8 UNDERSTANDING KEY POPULATIONS

Because the Avahan clinics serve populations that are often stigmatized by the larger community, counselors should learn as much as they can about the HRG communities they serve. This is particularly important as HRG clients may have had very negative experiences with service providers in other settings and may find it difficult to trust anyone from outside their own community. Counselors will be asking intimate questions and proposing changes of personal practices. To do this without an understanding of the HRG client and his or her community and situation is not likely to create trust or positive results. One of the key challenges of the Avahan clinics is to overcome the distrust that is the result of discrimination, and which contributes to the vulnerability of HRG clients to STI and HIV infections.

Counselors who are respectful, honest, and nonjudgmental are most likely to succeed in building trust. If a counselor does not have much experience with the HRG client groups, it is best for the counselor to tell the HRG client. Admitting a lack of knowledge and expressing a desire to learn and understand is unlikely to offend the client. The counselor can say that if he or she unintentionally says something hurtful, he or she hopes that the client will understand and point out a better way. Counselors should also remember that each client will be different.

Labeling HRG Clients

It is best to avoid using labels when talking with an HRG client unless your client provides one he or she feels comfortable with. Labeling can cause counselors to make incorrect assumptions. Using labels can also cause denial among clients who do not accept the label or the implications of a label. Counselors can focus on the actual behaviors that contribute to risk without using a label.

General Information

Counselors should pay attention to what a client is saying and how the client is saying it. Most of what we communicate is through body language: our expression, our decision to touch or to avoid touching, the distance we put between ourselves and others. The counselor must also pay attention to his or her own body language — people who are accustomed to discrimination are extra sensitive to this.

Counselors need to remember that it may have taken great courage for the client to come to the clinic, given how he or she may have been

treated by other care providers. Counselors will be asking very personal questions, and the answers to these questions are the very reasons that they are commonly stigmatized.

Clients have the right to know why the counselor is asking any question and what the counselor will do with the information. They have the right to know why they are talking with a counselor, what the counselor's role is, and what they can and can't expect from the counselor.

Clients also have the right not to answer questions, and must be reassured that they can still receive care for their problems. The burden of building trust is on the counselor, and this may take time.

Brief summaries about each high risk group are included in Annex 2.1. Each section provides some thoughts that were gathered by consulting with these members of the client populations:

- female sex workers
- men who have sex with men (MSM)
- male sex workers (MSW)
- transgender HRG clients — Aravani or Hijra
- male clients of sex workers, male partners of female sex workers

Counseling Session Guidelines

SECTION TWO

Photo: Anita Khemka

2.1 A FIRST COUNSELING SESSION — INTRODUCING HRG CLIENTS TO COUNSELING

Most HRG clients will not be familiar with counseling. It will be up to counselors to ensure that clients come to view counseling as a positive use of their time.

Prepare for the Counseling Session

Obtain and review the client's chart if he or she has already come to the clinic. Identify points you might want to go over with the client and gather relevant educational materials.

Build Rapport

Greet your HRG client, introduce yourself, and give him or her time to get comfortable. Make sure that there are no physical barriers or distractions between you and the client. **Assure the client of confidentiality — this is one of the most important values in your relationship.** Begin to establish a partnership with your client.

Explain the Role of Counseling

New clients are unlikely to have ideas about counseling, what a counselor does in the STI clinic, or even why they are talking with a counselor. Start by explaining what you do, why counseling is a part of STI care, and what happens during a counseling session. This is a good time to talk about confidentiality and shared confidentiality.

Explain how counseling sessions are managed: the amount of time you'll normally have and specific tasks you need to complete, such as the sexual history/risk assessment or other care issues. Explain that during counseling, you can work together with the client to help the client reduce his or her risk of STI or HIV infection. There may be other issues your HRG client will want to talk about once he or she is comfortable and trusts you.

Explore Reasons

On repeat visits, do not assume that you know why the client has come, unless it is for an agreed-upon and specific purpose, such as an HIV antibody test result. Ask an open question to encourage the HRG client to tell his or her own story. For example, "*What brings you to the clinic today?*"

2.2 TAKING A SEXUAL AND HEALTH HISTORY

The responsibility for taking a health and sexual history will vary in the clinics. Either the counselor or the doctor may take the health/sexual history during the first visit. This history should include assessment of *other* risk, such as injecting drug use or a drug-using partner. Whoever takes the history is responsible for making sure the information is written in the client's record immediately, because it will be needed by whomever the client sees next.

In clinics where the doctor takes the history, the counselor will need to review the recorded history when doing risk assessment and risk reduction planning. More in-depth assessment often needs to be done for this purpose, but it is best if the same questions aren't asked twice. This takes up valuable time and may be irritating to the HRG client. As the clients are being asked to share very personal information, the counselor should make sensitive use of interviewing skills to elicit accurate information. The counselor should explain that these questions are asked of all clients and they are asked to make sure the right care is given.

If the counselor sees the HRG client before he or she is examined by the doctor, the internal examination and syphilis screening should be explained and promoted.

The detailed history will include

- current and past sexual behavior (number of partners, types of partners, frequency of partner change, unprotected vaginal and/or anal sex)
- current and past sexual behavior of the HRG client's sexual partners, if known
- current and past drug and/or alcohol use, including injecting drug use by the HRG client and the client's partners, if known
- HRG client's and her/his partners' history of present and previous STI
- HRG client's history of blood transfusions (date, location, and whether the blood was screened for HIV)
- current and past exposure to non-sterile invasive procedures (injections, tattooing)

Counselors may also be expected to carry out verbal screening to rule out/in pregnancy of female HRG clients so that appropriate counseling can be given. This is also important for the clinician to know before prescribing medication. See Annex 2.4 Tool: Assessing for Pregnancy.

See Annex 2.1–2.5, which include guidance and checklists for counseling different HRG clients, a tool for assessing for pregnancy, and tips on conducting a first counseling session and answering questions commonly asked. Topics to be covered are also described in Annex N of the COGS.

2.3 PROMOTING INTERNAL EXAMINATIONS

When HRG clients come for STI screening or treatment, the doctor will do a speculum or anoscope examination. This may be different than any STI treatment the client has had before, as most doctors will treat based on reported symptoms or signs observed from an external examination. All HRG clients should be informed about the examination process and the purpose for internal examination. This may be done by the counselor or as part of the health

education given by other staff or volunteers in the clinic.

Health education about internal examinations should include

- explaining what is meant by "internal examination"' to detect STI that are found in the cervix and vagina (speculum) or the anus (anoscope)
- explaining the reason for internal examinations, and the importance in making a correct diagnosis
- explaining the process of the examination
- showing and allowing the client to handle the speculum or anoscope
- reassuring clients that it is a common procedure, recommended for all clinic clients
- reassuring clients about privacy and confidentiality in the STI clinic
- reassuring clients that the examination may cause a little discomfort, but is not painful, if the client relaxes

A PE or other HRG volunteer may be willing to share his or her own experience with an internal examination. This is one of the benefits of having a PE or HRG volunteer provide this health education.

The counselor should prepare the HRG client for an exam by checking on the client's understanding of points covered in the health education. The counselor should also ask the client about any previous experience with internal examinations and any concerns that the client may have about the examination.

Counselors may want to acknowledge that these exams can feel a bit embarrassing and assure them that the doctor is the same sex, or a female for transgender (TG) clients if this is preferred.

Counselors must be sure to remember that a female who has reported anal sex or anal/rectal symptoms during the sexual/risk history will also need an anoscope exam.

See Annex 2.4, Checklists and Tools for New HRG Clients, Checklist 4: Explaining and Promoting a Pelvic Exam, and Checklist 5: Explaining and Promoting a Rectal Exam for MSM and TG Clients.

2.4 EXPLAINING SYPHILIS TESTING AND TREATMENT

At the first visit, HRG clients will need a blood test to check for syphilis. If the test does not show signs of syphilis, it will be repeated every six months. Counselors need to make sure that HRG clients understand the importance of identifying and treating syphilis: This is an infection with very serious long-term effects that can be completely cured. Clients need to understand that syphilis does not always have signs or symptoms.

Health education should include information about signs and symptoms of syphilis, stages of syphilis infection, and what can happen if complete and correct treatment is not given. It should also include how the test is done and when the client will get his or her results.

If the client has signs that might indicate syphilis and the client remembers being treated for syphilis recently, the test will be repeated after three months.

If the client has signs that might indicate syphilis but the client does not remember being treated, he or she will be treated for the appropriate stage of infection, based on the syndromic management guidelines, and will be tested again after three months.

Counselors should make sure the client understands that this blood test is not an HIV test and explain that HIV testing can only be done after the client has given permission.

See Annex 2.4, Checklists and Tools for New HRG Clients, and Checklist 6: Explaining the Syphilis Blood Test.

2.5 EXPLAINING SYNDROMIC AND PRESUMPTIVE STI TREATMENT

Most clients will have had STI treatment from private doctors or "quacks." They may want to know why the treatment in the Avahan clinics is different. This is especially true when clients suspect the quality of free medicine, or feel that injections are better.

PRESUMPTIVE TREATMENT

All HRG clients are given medicine for common treatable STI because it is likely they have been exposed through unprotected sex with clients or regular partners.

These STI may not have signs or symptoms, and it may not be possible to do laboratory tests that can confirm an infection. As having an STI can make it easier to give or get HIV infection, it is best that STI be quickly treated and cured. This will prevent any harm the STI may cause and will prevent its being given to partners.

Many will wonder why they are being given so many pills or why they will be given medicine even when they do not have symptoms of an STI. These are concerns that can be covered by health education and reinforced during counseling.

Depending on the client's concerns, counselors should offer the following explanations:

- The Avahan clinics must follow strict guidelines to make sure that the quality of services is the best possible. The guidelines are based on years of research and they meet international standards for STI treatment.
- The doctors and counselors assess what a client needs by asking questions and by doing a careful physical examination so that nothing is overlooked. This is

important because many STI do not cause problems that a client will see or feel.

- Each clinic is monitored by a team of experts to make sure that the services meet the standards that are required.

Counselors will need to explain and answer questions about the presumptive treatment that will be given to HRG clients. All HRG clients will be treated presumptively for gonorrhea and chlamydia during the first clinic visit, whether they have symptoms or not. The presumptive treatment will be repeated if the client has not been seen in the clinic for six months or more.

See Annex 2.4, Checklists and Tools for New HRG Clients, and

Table 6: Answering Questions HRG Clients May Ask about Medicines.

2.6 STI AND HIV RISK REDUCTION COUNSELING

Counselors should spend some time during each counseling session helping the client reduce his or her risk of STI or HIV infection. Risk reduction means making any changes in behavior that would tend to decrease the chance of STI or HIV infection. This is not risk elimination, which would mean completely stopping all risk behavior, and thus no risk at all. For most HRG clients, this will not be a practical option.

All counselors should have complete knowledge of the risks of HIV/STI transmission, STI signs, symptoms and long-term effects, and options for safer sex to prevent transmission.

The planning process should be interactive and respectful of the HRG client's circumstances and readiness to change.

Gather information to identify possible risks.

The first step of risk reduction is to make sure the client believes he or she is at risk and knows what the risks are. If a sexual history has already been taken, or the client has already been diagnosed with an STI, the counselor should find this information in the client record. If it has not been done, the counselor will do the sexual history on the first visit. The counselor will explore the client's sexual and drug use history through discussions with the client.

Help the client to assess his or her risk of infection.

Counselors will help the client identify and recognize the connection between the modes of HIV and STI transmission and the client's own behaviors or practices that may put them at risk of acquiring and transmitting STI/HIV. Clients may not feel they are at risk, for various reasons, or they may believe that their chance of becoming infected is lower than it really is.

Counselors should be able to identify and clarify underlying incorrect information or

HELPING CLIENTS ASSESS THEIR RISK

- Based on the history, point out events or actions in the client's history that could lead to infection.
- Learn about their understanding of HIV and give additional information as needed. Probe for other possible risks.
- Discuss each of their risks in detail.
- Check for the client's level of concern about the different risks.
- Summarize the main points before moving on to risk reduction planning.

See Table 2: Practices and Risk: High, Low, Medium

beliefs using language easily understood by the client.

The counselor will also help the HRG client identify and explore other activities that make the client vulnerable to the risk of infection, such as drinking alcohol or drug use.

Check on previous efforts to reduce risk.

The HRG client may have already been making efforts to reduce his or her risk. Find out what the client has tried. Make sure what the client has done is an effective way of reducing risk and correct any misunderstandings. Give praise for any effort the client has made.

Assist HRG client to make a risk reduction plan.

The counselor will help the HRG client to decide how he or she wants to start reducing risk. The counselor will need to help the client make realistic choices about making changes and about steps the client will take. An action-oriented plan will be agreed upon and documented in the client record.

While making a plan, the counselor should also help the client identify any difficulty that may be faced when carrying out the plan. If the client can't think of ways to deal with the difficulty, the plan should be made simpler. Remind clients that they don't need to make big changes all at once; they can start small and go step by step.

➔ A step-by-step plan for small changes is more likely to be successful. This is important if the HRG client is to succeed and stay motivated.

Review and update the risk reduction plan at follow-up counseling sessions.

During each follow-up visit, the counselor will go over the plan, reviewing what was done and the results of any actions the client took to reduce risk. No matter what was tried and what the results were, the counselor should praise the client's effort, give encouragement, and work with the client to further implement the risk reduction plan. If there were problems, the plan may need to be simplified, or the client may need more assistance from the outreach team or more practice on skills.

The counselor should work in collaboration with PEs to make sure that each HRG client learns the correct technique of condom use,

and understands the importance of water-based lubricant use and condom negotiation skills. If the client needs other assistance, this may be discussed with PEs, with consent of the client.

Follow up on plans and plan for next steps.

See Annex 2.6, Risk Reduction, which contains information about safer sex, including alternatives to penetrative sex, and useful checklists, including Checklist 10: Counseling for Risk Reduction Planning and Checklist 11: Helping HRG Clients Use Male Condoms Correctly.

WHAT IS "SAFER" SEX?

Safer sex is any sexual activity that reduces the risk of transmitting or getting an STI, including HIV.

The only sex that is completely free of risk is no sex (abstinence) or sexual activity that does not allow the exchange of body fluids.

Body fluids include

- vaginal fluids
- blood
- semen or pre-cum (pre-ejaculate fluid)
- rectal mucosa/fluids

TABLE 2: PRACTICES AND RISK: HIGH, LOW, MEDIUM

Note: Some activities that cannot transmit HIV can transmit some STI. Any act that can transmit HIV can also transmit one or more STI.

Practice	Risk	Notes
Abstinence	No risk	
Masturbation	No risk	
Sex with a monogamous, uninfected partner	No risk	It is difficult to know if partner is monogamous and uninfected.
Unshared sex toys	No risk	
Shaking hands with an HIV-infected person	No risk	
Sitting on a public toilet seat	No risk	
Getting bitten by a mosquito	No risk	
Massage	No risk	
Hugging an HIV-positive person	No risk	
Sharing sex toys with cleaning or use of new condom	Low risk/No risk	
Sexual stimulation of another's genitals using hands	Low risk/No risk	Risk of HIV is very low if there are no cuts or broken skin on hands, especially if there is no contact with vaginal secretions, semen, or menstrual blood. Some STI that are passed through skin-to-skin contact are possible.
Deep (tongue) kissing	Low risk/No risk	Risk is higher if bleeding gums, sores, or cuts in mouth. No risk due to saliva itself.
Oral sex on a woman (cunnilingus) with a barrier	Low risk/No risk	Risk is very low. Barrier must be used correctly. Some STI (e.g., herpes) can be transmitted through contact with skin not covered by barrier.

continued

TABLE 2: PRACTICES AND RISK: HIGH, LOW, MEDIUM CONTINUED

Practice	Risk	Notes
Oral sex on a man (fellatio) with a condom	Low risk/No risk	Risk is very low. Barrier must be used correctly. Some STI (e.g., herpes) can be transmitted through contact with skin not covered by barrier.
Vaginal sex with a condom	Low risk	Small risk of condom slippage or breakage — reduced with correct use. Some STI (e.g., herpes) can be transmitted through contact with skin not covered by condom.
Vaginal sex with multiple partners; condom use every time	Low risk	Multiple partners increase risk; however, correct and consistent condom use lowers risk.
Anal sex with a condom	Low to Medium risk	Risk of condom breakage greater than for vaginal sex. Risk of breakage is decreased by use of water-based lubricant. Some STI (e.g., herpes) can be transmitted through contact with skin not covered by barrier. If after the anal sex, the penis with condom is inserted into a female partner's vagina, both HIV and other infection can spread due to fecal contamination.
Oral sex on a man (fellatio) without a condom	Medium risk	HIV and STI can be transmitted through oral sex; however, risk is lower than that of anal or vaginal sex. Safer if no ejaculation in mouth.
Oral sex on a woman (cunnilingus) without a barrier	Medium risk	HIV and STI can be transmitted through oral sex; however, risk is lower than for anal or vaginal sex.
Withdrawal (removing the penis before ejaculation)	High risk/ Reduced risk	HIV can be present in pre-ejaculate and, therefore, risk of transmission is high; however, withdrawal may reduce risk of HIV transmission somewhat. Unlikely to reduce risk of other STI. (pre-ejaculate: the fluid that comes out of the tip of the penis before the man comes)
Vaginal sex without a condom	High risk	One of the highest-risk activities. Receptive partner is at greater risk.

Practice	Risk	Notes
Anal sex without a condom	High risk	One of the highest-risk activities. Receptive partner is at greater risk, but the risk of the "active partner" is higher than originally thought. If the penis is then inserted into a female partner's vagina, HIV and other infections can be spread due to fecal contamination.
Fingers/hands/objects put into the anus	Medium risk of some infections	If the fingers/hands/objects are then put into a female partner's vagina, or either of the partners' mouths, infection due to fecal contamination can be spread.
Vaginal sex using hormonal contraceptives or intrauterine device (IUD) and no condom	High risk	Hormonal contraceptives and IUDs do not protect against STI or HIV.
Using sharp instruments to cut skin (e.g., instruments used for scarification, female genital cutting, tattoos)	High risk	If these instruments have been used on others and are not properly sterilized, HIV and hepatitis viruses could be transmitted.
Sharing needles, syringes, drug solutions, or other drug paraphernalia	High risk	HIV and hepatitis viruses can be readily transmitted from infected persons through sharing of paraphernalia for injecting drugs.
Injection in clinical settings	Unknown	If the clinic uses disposable needles/cutting equipment one time or sterilizes needles/equipment, there is no risk. If needles and cutting equipment are reused, there is a high risk — this may be common in services provided by "quacks" or others, such as pharmacists.
Breastfeeding from an HIV-infected mother	High risk	Although risk is relatively high, if no other good source of nutrition is available, it is recommended that HIV-positive women breastfeed.
Making love to your spouse	Unknown risk	It may be difficult to know whether your spouse engages in activities that put you at risk.
Receiving blood transfusion	Unknown risk	In many countries, the blood supply is adequately screened for HIV.
Occupational exposure to blood or body fluids	Varies depending on exposure	HIV and other pathogens can be transmitted through contact with blood or other body fluids. Risk can be minimized if universal precautions for infection control are followed with all clients.

2.7 COUNSELING ABOUT CONDOM USE

At each session, counselors should check with their HRG clients about their experiences with condom use.

It's important for counselors to remember that clients' motivation to negotiate condom use and their ability to use condoms successfully will vary. The kind of relationship they have with a partner, where they are having sex, and the amount of time and privacy they have for sex can all affect condom use.

Ask questions such as the following to find out more about a client's condom use. These types of questions can show clients that the counselor understands that condom use is not always simple, and that the counselor is not judging them.

- When do you find it difficult to use a condom?
- What are the times you find condom use more difficult?
- What are the times you or a partner would rather not be using a condom?

A client who does not feel judged or blamed is more likely to give an honest answer than if the counselor asks "Are you using condoms?" or "Why aren't you using condoms?" Knowing what is really happening makes it possible for the counselor to help the HRG client find ways to increase condom use or to plan other safer sex methods.

Teaching Condom and Lubricant Use

The main reason condoms break is incorrect use. Every counselor must teach HRG clients how to use a male condom and lubricant correctly. Counselors may do this themselves or may arrange to have it done as part of group health education in the waiting area. Health education may be conducted by a PE. Each HRG client should be asked to demonstrate and explain the steps of using a condom and lubricant to make sure he or she has learned correctly.

HRG clients should also be taught how to put a condom on using their mouth, and other techniques that will improve their ability to use condoms with their clients. Counselors who are not able to do this should ask a skilled PE to teach this.

Importance of Lubricants

Repeated vaginal sex tends to dry the vagina and irritate or cause tiny tears in vaginal walls. The anus produces little lubrication for sex, and lubricant will make introduction of the penis into the rectum easier, more comfortable, and less likely to damage the rectum.

"Dry" sex can also cause condoms to break. Counselors will help clients identify options and sources for lubrication as part of counseling about condom use. Counselors should ask what the HRG client is currently using for a lubricant during vaginal and anal sex, as the clients may

be using a variety of substances/liquids that may cause condoms to break.

HRG clients will be taught not to apply petroleum jelly (e.g., Vaseline), cooking oil, baby oil, suntan oil, massage oil, or hand lotions when using condoms, as oil-based lubricants damage the latex and weaken male condoms, causing them to break. Counselors or PEs providing

Steps for Using Male Condoms	More Information
Check the package and the expiration date.	If the package is torn or damaged, or the expiration date has passed, don't use the condoms.
Open the package carefully and take out the condom.	Do not use your teeth, scissors, or other sharp objects, or you may tear the condom.
Put the condom on before there is any contact between the penis and the partner's genitals/ mouth/anus.	Condoms can only be put onto an erect penis.
Hold the condom by the tip. The roll of the condom should be on the outside.	
Pinch the tip, place the condom on the tip of the penis, and roll it down the length of the erect penis.	Air inside the condom can cause friction that will break the condom. If the condom doesn't unroll smoothly, it may be wrong side out: check.
Add water-based lubricant to the outside of the condom if more is needed.	A small amount of lubricant can also be placed inside the tip of the condom before putting it on, to increase sensation. Small amount = size of a pea. Too much will cause the condom to slip off.
Pull the penis out after ejaculation, before the penis becomes soft.	The condom is more likely to slip off and spill if the penis is soft. Hold onto the condom at the base of the penis while pulling out.
Remove the condom without spilling any liquid from inside. Use a tissue to avoid touching the inside or outside of a condom that has had contact with body fluids. Wrap used condom in a tissue/paper and dispose of it in dustbin/garbage.	Don't flush in toilets as condoms can stop up plumbing pipes.

health education will explain and demonstrate how oil-based lubricants damage the latex.

Water-based products like K-Y lubricating jelly work well with male condoms. The counselor will need to work with the HRG client to identify lubrication that is available and affordable.

Both water-based and oil-based products can be used with female condoms. Water-based products like K-Y lubricating jelly and oil-based products like body oils, creams, lotions, or petroleum jelly may be used as a lubricant for female condoms as they are made of polyurethane and not latex.

Condom distribution is part of every counseling session. All HRG clients and their partners should routinely be given condoms.

See Annex 2.6, Risk Reduction, especially More Information on Safer Sex, Checklist 11: Helping HRG Clients Use Male Condoms Correctly, Table 7: Ways to Help HRG Clients with Worries about Condoms, and Table 8: Choosing the Right Barrier Method.

2.8 HELPING HRG CLIENTS LEARN SKILLS: NEGOTIATING SAFER SEX, INCLUDING CONDOM USE

Counselors will help HRG clients to identify safer sex options and practice negotiation techniques as part of risk reduction planning.

Counselors will explore the situations in which a client is not consistently using condoms and what contributes to their difficulty in negotiating and using condoms. HRG clients will be assisted in identifying practical options for increasing condom use. If condom use isn't possible, HRG clients should be encouraged to offer and negotiate other safer sex techniques with the partner. Counselors need to make sure that the HRG client understands that "less risk" is not the same as "no risk."

Condom Negotiation with Clients and Casual Partners

HRG clients will need adequate skills to negotiate condom use or other safer sex activities with their clients and casual partners. Counselors are responsible for ensuring that HRG clients have the skills they need. If the counselor is not knowledgeable, or there is not enough time during a counseling session, the counselor should make arrangements with skilled PEs to work with the client.

Learning skills and gaining confidence require practice. Role plays can be a good way to help an HRG client try out different ideas for

CONDOM NEGOTIATION TIPS

- Be assertive rather than pleading. Start out with the assumption that the client will agree; in fact, act as if everyone is using condoms and you can't believe he would make any other choice.
- Have the condom ready and use your hands/mouth or talk sexy to get the client excited; slip the condom on without stopping the contact or sexy talk.
- If he disagrees, explain with confidence that you are using condoms to make sure he has a good experience and no regrets. "I'm sure you know that it's possible to have an infection and not know or show. Why would anyone want something like that?"
- If he absolutely refuses a condom, suggest oral sex or masturbation, or sex between your breasts. Explain that you take your responsibility to protect yourself and everyone else from HIV infections seriously.
- In place of anal sex, learn how to reach between your thighs and use your fist and lubricant to make a "fake" anus or vagina; this works well especially if the client has been drinking.
- Take the client's penis between your thighs pressed tightly together.
- State firmly and clearly that your life and health are more important than his money.
- Before the sexual activity begins, ensure that your partner has condoms and is willing to use them or is willing to use condoms you have.
- Persuade your partner to let you put on the condom and say that using a condom is very exciting. (Do it, don't talk about it.)
- State the reason for refusing sex without condoms, in a firm manner.
- Tell your partner that in addition to your concern for your own safety, you are concerned about his or her safety.
- Explain that you are using condoms to prevent pregnancy.
- Propose other ways of having sexual pleasure without penetrative sex.
- Always be conscious of situations you may not be able to handle and avoid them or have a well-thought-out escape route.
- Always have condoms available.

negotiation. The role plays may best be done with a PE, as peers are more likely to be familiar with the situations and negotiation issues the HRG client is facing.

Condoms and Safer Sex with Casual Partners, and Reducing Number of Partners

Help the HRG client understand that having multiple partners in the same time period (concurrent partners) increases the chance of spreading HIV. Having fewer partners means less risk — but it does not mean no risk.

Reducing the number of partners may be very difficult for HRG clients who depend on high numbers of partners for their earnings. However, counselors should not assume that HRG clients have multiple partners only for economic reasons. Some HRG clients may have some or all of their partners for pleasure or other personal reasons; for these clients, reducing partners may be more appropriate. Discuss options for reducing risk with casual partners.

Make sure your HRG client is reminded of the increased risk created by having multiple partners who also have multiple partners. You may do this by asking the HRG client if he or she thinks a current partner has other partners or has had other partners in the past.

Condom Negotiation with Husbands and Regular Partners

HRG clients are less likely to use condoms with regular clients, and especially with regular partners. They may have long-term partners, lovers, or "husbands." The HRG client's partner may not know of his or her sexual activities outside of their relationship. This can be true for men, women, and men who have sex with men (MSM). Counselors need to be sensitive to how the HRG client feels and thinks about the different relationships. Raising the issue of risk and condom use with a partner with whom the HRG client has (or wants) a personal relationship is different from doing this with a paying client.

During risk reduction planning, ask the HRG client if he or she and his or her partner know whether the other has other sex partners, or if they have ever talked about the risks of STI or HIV.

The counselor will need to help the HRG client deal with fear of rejection, which may or may not be realistic. If the partner doesn't know the HRG client has other sex partners and the HRG client can't tell the partner, the counselor should encourage the HRG client to protect the partner by using condoms in all other relationships or sexual activities.

If a partner does know about the other partners, and they haven't talked about risk, work with your client to help him or her bring this up with the partner as a first step in risk reduction.

Help HRG clients consider how condom use and protecting a partner fits with the importance of love and trust in the relationship. Not using a condom is putting the lover, husband, or wife at risk of infection. The HRG client may focus on love and the importance of the relationship when talking with a partner about using condoms. Condoms can also be discussed as a pleasurable tool for extending lovemaking and making sex less messy when there is ejaculation.

Counselors should ask an HRG client if it would be possible to introduce condoms with their regular partner as family planning, if this is relevant. Remind the client that condoms prevent unwanted pregnancy as well as STI or HIV infection.

If the client and his or her partner have talked about risk, learn more about their discussion and help the client to build on that. Suggest that the client invite the partner for a counseling session if that would be useful.

See Section 2.15, Counseling Couples.

2.9 COUNSELING CLIENTS WHO HAVE BEEN DIAGNOSED WITH AN STI

HRG clients may be more convinced of their risk if they have an STI on the day of their visit. This may make them more interested in the health education and counseling being offered, and more motivated to make changes. Counselors should make sure the client has a chance to reflect on how he or she got the current infection and how this can be avoided in the future.

Explaining STI Treatment

Avahan clinics will be treating HRG clients based on the syndromic and enhanced syndromic guidelines as specified in the COGS.

Counselors are responsible for making sure that HRG clients understand the diagnosis and treatment, and are assisted to take medicine at the clinic or to plan for taking medicine that will need to be taken over a period of days. Go over the following points:

- Explain that the examination or test showed that they have an STI. Inform them that most STI can be cured completely, provided medicines are started as early as possible, the drugs are taken correctly and completely, all partners are treated simultaneously, and the client can return for regular follow-up. Medical treatment can help with symptoms of other STI that can't be completely cured.
- Provide health education about STI and the importance of correct treatment.
- Find out if the client is taking any other medicine or treatment for the STI. symptoms and clarify any misconceptions.
- Explain any interaction with alcohol, any other side effects, and what to do about them.

For some STI syndromes, the HRG clients will be taking all of the prescribed medicine all at once, while they are at the clinic. Explain the purpose of the drugs being given and possible side effects, and make sure the client has enough water to swallow the pills. Some medicine causes upset stomach. If possible, offer biscuits along with the medicine.

For other syndromic treatment, the client will need to take medicine at specific times of the day over a number of days or even weeks. If the client needs to take medicine correctly outside of the clinic:

- Explain the purpose of the drugs being given and possible side effects.
- Ask the client to point out each different medicine and to say how he or she will take it: periodicity, number/s of pills each time, and number of days.
- Make sure that instructions are written or diagramed on the drug container or packet.

- Explain to clients that they will probably feel better before all the medicine has been taken. Emphasize that they need to take all the medicine, even though they will start to feel better before it is finished. Explain that the infection can come back even stronger if they don't take all the medicine, and it may be harder to treat in the future.
- Prepare a plan with the client to make sure he or she will be able to take all the medicines as prescribed, and give a written reminder. Identify any possible problems clients may face when taking the medicine as they've been taught and offer solutions for these.
- Review the plan with the client to ensure that he or she has understood.
- Encourage clients to get in touch or come to the clinic if they have any problems with the medicines.

Trained PEs can provide health education about STI treatments and the importance of taking all the medicine exactly as instructed.

Counselors will need to make sure HRG clients understand the reason for getting a partner treated and help clients make a practical plan for how best to do this. Arrange for the help of a PE if this will be useful to the client.

This may also be a good time for counselors to raise the issue of having an HIV test and explain the reasons why this is being suggested. If it was possible for them to get an STI, it was also possible that they may have been exposed to HIV. Remind the client that if either partner has an STI, HIV is more easily transmitted.

See Annex 2.7, Checklists for Counseling on Specific STI Syndromes, including Checklist 12: Explaining Treatment for Cervical Infection (STI Treatment Speculum Examination), Checklist 13: Explaining Treatment for Vaginal Discharge, Checklist 14: Explaining Treatment for Urethral Discharge, Checklist 15: Explaining Treatment for Scrotal Swelling, Checklist 16: Explaining Treatment for Proctitis (Inflammation of the Rectal Wall), and Checklist 17: Counseling for Treatment of Infection in the Throat.

Also see Annex 2.8, Counseling for Partner Notification, Checklist 19: Helping HRG Clients with Partner Notification and Treatment and

Also see Annex 2.10, Counseling to Promote HIV Testing, Checklist 20: Recommending an HIV Test to Your HRG Client.

TABLE 3: SIGNS AND SYMPTOMS OF STI

Common Signs and Symptoms for Both Males and Females
• painless red sores on the genital area, anus, tongue, or throat • a scaly rash on the palms of the hands and soles of the feet • swollen glands, fever, and body aches • unusual infections, unexplained fatigue, night sweats, and weight loss • pain in or around the anus for clients who have had anal sex
Common Signs and Symptoms for Females
• more discharge than usual; it may be watery, milky, have a yellowish or greenish color, and smell bad • itching and redness around the vagina • sores, warts, blisters, or lesions on the vagina, genital area, rectum, or in the mouth • pain during sex, or bleeding during sex (this may have other causes) • pain or burning while urinating • pain in the pelvic area • sore throat (related to oral sex) **Remember: women may have vaginal, oral, or anal sex.**
Information That the Counselor Must Give Female Clients
• Even if the signs or symptoms go away or are not visible, it does not mean that the STI has gone. The client may still be able to infect people if she has unprotected sex. • There won't be any signs and symptoms for certain types of STI. This is especially common in women. For example, a fair proportion of women with gonorrhea or chlamydia are likely to be asymptomatic. This is why Avahan promotes regular checkups. • Women are more likely to have asymptomatic infections than men, and also have greater biological susceptibility to acquire HIV infection if exposed. • Untreated STI in women can lead to pelvic inflammatory disease (PID), infertility, ectopic pregnancy, pregnancy loss, neonatal morbidity, and mortality. • For both males and females, STI create an increased risk of HIV transmission for either partner.
Common Signs and Symptoms of STI for Male Clients or Male Partners of Female Clients
• discharge or pus coming from penis or rectum • a burning sensation, irritation, pain during or after urination, or frequent urination • ulcers, warts, blisters, or lesions on penis, genital area, rectum, or in the mouth • itch in the pubic hair, on the tip of the penis, or in the rectum • swollen glands in the groin • pain or swelling in one or both testicles • soft, flesh-colored warts around the genital area • sore throat in men who perform oral sex
The counselor must give male clients the same information as females, and in addition must explain:
Untreated STI in men can lead to an increased risk of HIV transmission, epididymitis, infertility, Reiter's syndrome (a type of arthritis that occurs as a reaction to infection), and rectal fistula (a severe ulcer in the rectum that causes drainage of feces).

2.10 COUNSELING FOR PARTNER NOTIFICATION AND TREATMENT

Partner notification and STI treatment are needed to prevent STI reinfection, further spread of the STI, and possible long-term effects of untreated STI for the partner. However, telling a partner is often very difficult for an HRG client and can lead to conflicts and distrust in a relationship. Clients will need to feel convinced that the benefits are greater than the possible problems, and may also need to feel convinced that partner notification and treatment is needed even if the partner does not show any symptoms. Assuring a client that confidential STI treatment services will be given to a partner may help motivate him or her.

Counselors need to remember that partner notification is always voluntary. Counselors may be able to offer the help of a trusted PE or ORW, and HRG clients can also consider bringing their partner to the clinic to see the counselor.

Counselors should focus first on regular partners while counseling clients on partner notification and helping them to plan for it. Counselors will need to keep in mind that "regular partners" are likely to change. Many HRG clients will not have long-term, exclusive relationships; they may have short- or long-term sequential relationships with a regular or primary partner, or they may have more than one regular partner at the same time, in addition to casual or commercial partners. Their regular partner may also have other commercial, casual, or regular partners.

Once the HRG client has agreed to notify a partner, counselors will help the client to explore the best way — when, how, and where — to tell the partner and the different ways a client can make sure a partner gets treatment. Counselors should discuss how the partner might react to the news and what the client could do to decrease the chance of rejection, conflict, and abuse.

HRG clients may find it useful to role-play what they might say. Trained PEs can be very helpful with this, if working with them is agreeable to the client.

See Annex 2.8, Counseling for Partner Notification, including Checklist 19: Helping HRG Clients with Partner Notification and Treatment.

Also see Section 2.15, Counseling Couples.

2.11 COUNSELING ABOUT FOLLOW-UP ON STI TREATMENT

At the end of a clinic visit, all HRG clients who receive STI treatment should be encouraged to come for a follow-up visit. Counselors will explain the reason for the follow-up visit, emphasizing the importance of coming back to see the doctor, even if all symptoms have gone.

Counselors should use follow-up visits to go over the following:

During a Follow-up Visit:	Questions and Counseling
Find out if the client took all the medicine as instructed and planned.	Ask if the client had any problems taking the medicine, remembering to take the medicine, or with side effects.
Find out whether the client's symptoms (if he or she had any) are completely gone.	If the client has symptoms, find out if this might be a new infection, if the client wasn't able to take the medicine correctly, and whether the regular partner was treated.
Find out if partners were notified and/or if they got treatment.	The client may or may not have notified a partner. Even if the client hasn't directly notified the partner, he or she may have found some other way to get a partner treated. Remind the client that if their partner has not been treated, he or she may have become re-infected. Encourage the client to have a checkup for re-infection and work again on partner notification/treatment.
Find out how the client's risk reduction plan worked, reinforce any positive steps, and update the plan.	Bring out the risk reduction plan from the client record.
Address any other issues and concerns as usual.	

2.12 COUNSELING FOR STI TREATMENT FAILURE OR RE-INFECTION

An HRG client may come back to the clinic with symptoms of re-infection, or possibly with the same problem, after being treated.

The counselor should be careful not to judge the client if something wasn't done correctly.

- Go over the problem that caused the client to come back and explore possible reasons for this infection with the client. Reassure the client that partner notification and taking many medicines can be difficult.
- Assure the client that coming back was the best thing to do.
- Make a plan for the new treatment, including getting help from an HRG friend/PE.

Possible causes are:

- It is a new infection.
- The client has been re-infected by a partner who was not treated before.
- The client did not take medicines correctly and completely, so the original infection returned.

See Annex 2.6, Risk Reduction, Checklist 10: Counseling for Risk Reduction Planning.

Also see Annex 2.7, Checklists for Counseling on Specific STI Syndromes, including Checklist 18: Counseling for Treatment Failure or Re-infection.

2.13 COUNSELING MALE AND FEMALE INJECTING DRUG USERS (IDU)

An HRG client's drug use or dependency, or a drug-using partner, may be identified while taking or updating a health history or when helping a client with risk assessment.

This guideline does not cover drug use counseling. Counselors working in areas where there are high numbers of IDU should make sure their clinic has effective referral agreements for specialized IDU services. A counselor in the STI clinic is responsible for identifying drug use and making a referral if the HRG client is interested and there is an appropriate service available.

For drug-using clients, the counselor should be able to provide basic HIV prevention information relating to drug injection. Counselors will need to help an HRG client consider that how and when drugs or alcohol are used may increase vulnerability, and include plans for this in the risk reduction plan. Other counseling will be much the same as with non-drug-using clients and issues of sexual risk.

See Annex 2.9, Counseling IDU, which includes background information for counselors on injecting drug use and information on preventing bloodborne infections and reducing risks for IDU.

Safer Sex Issues for IDU

Remembering to practice safer sex is difficult when a person is high/intoxicated by drugs, just as with alcohol. Drug dependency also brings additional challenges for safer sex:

- Counselors need to be aware that HRG clients may be selling sex to pay for their own drug use or for their partner's drug use. A client who is dependent on drugs is especially vulnerable to having unsafe sex when they are feeling early symptoms of withdrawal and an overwhelming need to buy and use the drug.
- Many IDU feel that safer sex is an unimportant issue when they are at greater risk due to sharing injections.
- Being high/intoxicated by a drug and long-term drug use may make it difficult for men to achieve the erection needed to use male condoms effectively.

Female Drug Users:

- may need to sell sex to pay for drugs for themselves and/or for their partner
- often start using drugs because of pressure from their partner
- are likely to be in relationships with IDU and sharing injections with their primary partner

SAFER SEX ISSUES FOR IDU

Issues	Points to consider in counseling
Difficulty in finding and reaching out to IDU due to stigmatization or criminalization of this behavior	Find ways to access IDU through peer referrals. Make visits to programs serving drug-using populations to establish trust with them. Assure the client of confidentiality and anonymity.
IDU are at high risk of HIV and other bloodborne infections through unsafe injection practices. Many are aware of this and are less concerned about sexual risk.	Learn from IDU program outreach workers and peer educators what might motivate IDU to use condoms, and how to reduce risks associated with drug use. Make sure the client knows the basics of risk and preventing infection through injecting practices.
IDU are at very high risk when sharing injecting equipment and drug solutions that contain contaminated blood, because the HIV can be injected directly into the blood stream. IDU are also at very high risk of hepatitis B and C.	Use the IDU checklist to talk an IDU through the drug-using process, from purchase to use. Without doing this, it can be easy to miss an action that can spread HIV or HbC.
Drug use is usually illegal, and these laws may be more strictly enforced than laws about sex work.	Drug-using clients may need extra reassurance of confidentiality from counselors.
IDU are often best counseled by ex-drug users or those who are on drug maintenance therapy who have better insights or, at a minimum, someone who is experienced in working with drug-dependent clients.	This is a clinic decision. If you cannot do this, make sure you have someone of this description to review your counseling with you.
Male and female IDU often have multiple sex partners. Females may sell sex to support their drug habit and/or that of their partner. Males may have regular and commercial sex partners. Some male IDU may also sell sex to support their drug dependence.	Counsel on safer sex. If a drug habit is a reason for selling sex and unsafe sex, discuss referral to drug rehabilitation services. If possible, put the IDU in touch with a needle/syringe or drug substitution program.
Drug rehabilitation requires expert intervention. If possible, identify a resource in your area for referral. Even with expert treatment, relapse is very common. Drug users may stop and start many times.	Counselors in STI clinic settings should focus on helping IDU identify and work on risk reduction plans. If possible, put the IDU in touch with a needle/syringe or drug substitution program.
Drug use may lead to unsafe sex because people who are high on drugs find it more difficult to think about safer sex and to use condoms successfully.	When counseling people on safer sex, explore their use of drugs and how this might put them at risk. Discuss ways to reduce their risk, including keeping condoms with them when they go out to get drugs.
HRG clients accessing services may be intoxicated and may not be able to think clearly when they are under the influence of drugs.	Counsel HRG clients only when they are not intoxicated.

HOW DO STI AFFECT THE RISK OF HIV TRANSMISSION?

If either sexual partner has an STI, this increases the chance that HIV can be spread from an HIV-positive to an HIV-negative person. This is true regardless of which partner has the STI.

This happens for the following reasons:

STI cause breaks in the mucosa (the lining of the vagina, mouth, and rectum). The breaks may be too small to see with the eye, or they may be sores large enough to see clearly, but breaks of any size can allow HIV into the body.

STI also cause activation of the immune system, which means that there will be more "fighter cells" (CD4+ T cells) present in the area of the infection. These fighter cells are the same cells that HIV takes over, so it's easier for HIV to find its "new home" once the infection gets into the body through these breaks.

For a person with HIV, infection with some STI can increase the amount of virus in the body.

2.14 PROMOTING HIV COUNSELING AND TESTING

Anyone who has been exposed to an STI may have been exposed to HIV. The counselor should propose that all HRG clients consider an HIV test, explain why this is being suggested, and explore the client's feelings about the advantages and disadvantages of knowing one's HIV status; that is, whether or not one has HIV infection.

Exploring the Advantages and Disadvantages of Being Tested

All HRG clients should be provided with the facts they need to make an informed choice about HIV testing. Counselors should ask the client what he or she thinks the disadvantages of knowing his or her HIV status might be, and then what the advantages might be.

If the client is interested in learning more about an HIV test, explain the counseling and testing procedure, where this counseling can be done, and where the HIV test is available. If the client is willing to have an HIV test, the counselor should make an appointment for pre-test counseling, if the counselor is trained to provide this, or make a referral to the nearest integrated counseling and testing center (ICTC) center for voluntary counseling and testing (VCT).

If the HRG client is not ready for an HIV test, the counselor should acknowledge that many people are afraid at first. Counselors should explain that the tests can be done at any time and that they will be happy to talk more about this with the client in the future.

In most cases, STI counselors will be referring HRG clients to ICTC sites for full pre- and post-test counseling and testing. Counselors may also provide referrals for additional services for clients who have positive test results.

Counselors in Avahan STI clinics should, at a minimum, be able to do the following:

- Explain the HIV test and reasons why the test is being suggested.
- Help the client assess the costs and benefits of knowing one's HIV status.

- Provide a referral for the test if the client is interested.
- Arrange to have the client accompanied, if this is a part of the services offered by the specific implementing partner (IP) and is agreed to by the client.
- If the test results are positive or if the HRG client shares a positive result with the counselor, the counselor should assist the client in disclosing HIV-positive status to person/s of his or her choice.
- Plan for risk reduction with both HIV-negative and HIV-positive clients.
- Follow up on risk reduction efforts.
- Make appropriate referrals, including to HIV-positive support groups.

See Annex 2.10, Counseling to Promote HIV Testing, Checklist 20: Recommending an HIV Test to Your HRG Client, and

Annex 2.11, Overview of HIV Pre- and Post-Test Counseling, which includes guidance on counseling HIV-positive HRG clients.

IMPORTANT

- If the STI counselor is expected to fulfill the role of HIV VCT counselor, the counselor should also be trained using the NACO 1CTC guidelines and training curriculum.[1] Suggestions and checklists in these guidelines relating to HIV testing are not expected to substitute for such training.
- A summary of pre- and post-test steps is included in the Annex checklists for reference only or for use if the counselor has been trained as an HIV counselor.
- This guideline and the current STI counseling do not cover "positive prevention" counseling, as this requires another complex set of information and skills that would need to be covered in additional training.

TABLE 4: ADVANTAGES AND DISADVANTAGES OF HAVING AN HIV TEST

Advantages	Disadvantages
• Client can be supported to take steps to protect self and partner/s from HIV infection or re-infection. • If positive, can start taking steps to preserve health and monitor health so that antiretrovirals (ARVs) can be started at best time. • Can seek out others who are also HIV-positive to increase support and understanding, and to learn skills and information for coping. • Counselor can help client join a support group. • Test can end stressful uncertainty, give client ability to take action. • Knowledge and self respect can come from knowing that they have taken steps to protect self and others. • Pregnant women/couples can make informed choices about pregnancy, childbirth, and infant feeding. • Pregnant HIV-positive women can receive appropriate care to ensure healthy pregnancy and decreased chances of passing infection to child.	• Some chances of others finding out positive status if confidentiality not kept. • Adds to the burden of prevention faced by sex workers. • Rarely, people may get false positive or negative result and suffer distress and severe consequences unnecessarily. Or they may worsen their own health or infect others unknowingly. • Getting a positive diagnosis is stressful and frightening. It takes time to come to terms with this. • People with a positive result may lose their marriage, children, home, and jobs. Women may be vulnerable, isolated, abused, and stigmatized. • People with negative results may be complacent and may have more risky sex. • If a person with positive results does not have the power to do anything about it, she or he is likely to become very anxious or depressed and may feel there is no sense trying to protect him or herself or anyone else.

2.15 COUNSELING COUPLES

Counseling couples — HRG clients and their partners — can be very helpful to HRG clients who are in long-tem relationships. Most people, including HRG clients, find it very difficult to start a discussion about risk and safer sex with a regular partner. Counseling both partners may help them make decisions about sexual behaviors that both can accept.

The counselor should show support and care to both partners equally. During a couples' counseling session, the counselor should be careful not to favor either partner as this may limit the willingness of the other partner to participate in the discussion.

TIPS FOR COUNSELING COUPLES

- Create a trusting relationship with both partners.
- Let them know that each will have an equal opportunity to talk.
- Let them know that the feelings and opinions of both partners are important.
- Manage the discussion:
  - › Let the dominant-looking partner start. This may influence how the couple interacts when they get home.
  - › Do not let the more talkative person take over the session.
  - › Help a silent partner share his or her feelings and options.
  - › Make sure that both partners listen carefully to each other.
- Do not judge or take sides.

2.16 REPRODUCTIVE HEALTH COUNSELING FOR HRG CLIENTS

Counseling to Avoid Unwanted Pregnancy

All HRG clients have sexual and reproductive rights. Counselors will need to assess each client's desires to achieve or prevent pregnancy, regardless of sex or sexual identity. Keep in mind the possibility that male HRG clients may have a regular female partner, regardless of their sexual preference. Having a child may be important in this relationship. Married men who have sex with men (MSM) or male sex workers (MSW) may also desire children or need to meet family expectations for children. Many female HRG clients also will want to have children.

If the client has a regular female partner or is a female, ask about desires for a pregnancy. The following are examples of questions a counselor may ask to get the necessary information:

- Does the client wish to have a child or is having children important in their relationship?
- If not, is the client taking steps to prevent pregnancy?
- What contraceptive method is the client using?
- Is the contraceptive method being used consistently?
- Is the client happy with the method?
- Is the client having any problems getting supplies for or using a contraceptive method?

Counselors should provide all necessary information and help each HRG client make an informed decision about becoming pregnant, having a partner become pregnant, or preventing a pregnancy. Clients will need to know how they can prevent unwanted pregnancy and how well each contraceptive method will or will not prevent STI, including HIV. Table 5 covers the basic information.

Counselors should remind all HRG clients that sexual activity leading to pregnancy also carries the risk of exposure to HIV and other STI. Encourage condom use as the method that will prevent both pregnancy and STI, but do not limit your discussion if the client would like to use another contraceptive method. Realistically, many of your clients will not be using condoms 100% of the time with regular partners and may need a backup method to prevent pregnancy.

A female HRG client's pregnancy status should be assessed at every clinic visit by recording the last menstrual period. This will also be important because of medication being taken.

See Annex 2.1–2.5, which contain checklists for new HRG clients and a tool for helping determine if a client is pregnant.

If an HRG client needs more information, counselors should refer questions to the doctor or nurse at their clinic. Counselors will also be making referrals for the family planning services, products, and supplies needed by their clients.

2.17 COUNSELING FOR SPECIAL NEEDS

Some HRG clients will have special needs. These may include counseling about pregnancy and risk reduction during pregnancy, counseling about pregnancy termination, or counseling after sexual violence.

What HRG Clients Need to Know about Pregnancy, STI, and HIV

If an HRG client wants a pregnancy, or if she or the female partner is already pregnant, counselors should discuss the risks to a fetus and newborn if a mother has an STI or becomes infected while pregnant or breastfeeding. Condom use should be promoted to prevent infection by STI or HIV that can be transmitted to a fetus during pregnancy, birth, or breastfeeding.

Counselors should make sure the HRG male or female client understands it is more likely that some STI, such as herpes and HIV, will be given to the baby before it is born if the infection is new — that is, if the mother becomes infected while she is pregnant. This is because the mother doesn't have antibodies to fight the germs and they can increase very quickly.

Family planning should also be discussed and plans made for after the birth. Counselors should make sure the HRG client is encouraged to think about using a backup family planning method, if the client isn't sure that condoms will be used 100% of the time.

Counselors should discuss syphilis testing and STI checkups with an HRG client who wants a pregnancy, is pregnant, or whose partner is pregnant, and explain that STI screening in case of pregnancy is especially important.

This is a good time to counsel about the risks of HIV infection during pregnancy. Encourage the client to have an HIV test, make sure the client understands the benefits of knowing his or her HIV status, and tell the client about programs set up to prevent parent-to-child transmission (PPTCT).

Female IDU or heavy drinkers should be counseled on the effects of drugs and alcohol on a fetus (for example, the baby may show signs of withdrawal symptoms).

If the client is uncertain about whether she is pregnant, the counselor should help her to confirm the pregnancy. If the counselor's clinic does not offer pregnancy testing, the client may either buy a home pregnancy-testing kit from a

TABLE 5: CONTRACEPTIVE METHODS AND STI PREVENTION EFFECTIVENESS

Method	Effects on STI Transmission	Side Effects	Guidelines for Effective Use
Barrier Method			
Male latex condom	Protects against STI including HIV when correctly used for each act of intercourse	Rare: Irritation and allergic reactions	One used for each act, put on erect penis just before sex, used one time
Female condom	Protects against STI including HIV when correctly used for each act of intercourse	Very rare: irritation	Can be put in up to 4–8 hours before sex; used one time
Hormonal Methods			
Oral contraceptive	No protection	Changes in menstruation, mood changes, breast tenderness, weight gain, problems with blood circulation	Taken daily for x days, off for x (exact instructions will depend on brand/type). Must remember to take on schedule. Not recommended for women over 35 years old, smokers, and women with high blood pressure.
Injection (DMPA)	No protection	Menstrual changes, spotting between periods, weight gain, some delay in return to fertility after stopping	One injection every three months
Emergency contraception	No protection	Menstrual changes, nausea and vomiting	Must be taken within 72 hours of unprotected sex
Other Methods			
Intrauterine device (IUD)	No protection Not recommended for women at risk of STI	Cramps, heavy menstrual bleeding, pain, anemia, infertility with PID	Effective for multiple years. Must be inserted and removed by trained providers.
Surgical sterilization Vasectomy – male	No protection against STI	Pain, infection, possible surgical complications (rare)	Permanent method
Tubal ligation, tubectomy – female	Tubal ligation may reduce risk of PID	Pain, infection, possible surgical complications (rare)	Permanent method

Sources: Adapted from *Network*, "Family Planning and STDs," Family Health International, Vol. 14, #4, May 1994 and *Family Planning: A global handbook for providers*, World Health Organization and Johns Hopkins Bloomberg School of Public Health/ Center for Communications Programs, 2007.

pharmacy, or the counselor may make a referral to a laboratory offering the test.

See Annex 2.1–2.5, which contain checklists for new HRG clients and a tool for helping determine if a client is pregnant.

Promote prenatal care for pregnant HRG clients or an HRG client whose partner is pregnant. Make a referral for prenatal care if the HRG client is female, and talk with the male HRG partner of a pregnant woman to help him get his partner the care she needs.

Explain that prenatal care is more than just healthcare while a woman is pregnant. Healthcare providers may discuss many issues, such as nutrition and physical activity, what to expect during the birth process, and basic skills for caring for the newborn. A pregnant woman is expected to see the healthcare provider more often as her due date gets closer. A typical schedule includes visiting the doctor about once each month during the first six months of pregnancy; every two weeks during the seventh and eighth month of pregnancy; and weekly in the ninth month of pregnancy.

If the client is over 35 years old or the pregnancy is high risk because she has certain health problems, like diabetes or high blood pressure, the doctor will probably want to see her more often.

Counseling for Pregnancy Termination

Counselors may also receive questions about terminating an unwanted pregnancy. Pregnancy termination is legal in India when it meets certain conditions, which are described below. Any woman age 18 or over can legally request and sign for an abortion.

The Medical Termination of Pregnancy (MTP) Act 1971 states that

1. Notwithstanding anything contained in the Indian Penal Code (45 of 1,860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.
2. Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner,
   a) Where the length of the pregnancy does not exceed twelve weeks if such medical practitioner is, or
   b) Where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are, of opinion, formed in good faith, that -
      (i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities to be seriously handicapped.

Explanation 1 - Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation 2 - Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

Unsafe Abortion

Although abortion or MTP is legal in India, by far the majority of abortion is done by practitioners who are not legally qualified. This can be extremely dangerous and can result in serious infection, death, or loss of fertility. Counselors should assess a client's intentions, counsel her away from an unsafe abortion, and make an appropriate referral for pregnancy termination. Counselors should also make sure clients understand that MTP for sex selection is illegal, and should counsel the client to select a family planning method that will prevent future unwanted pregnancies.

Post-abortion Care

Women need prompt medical care if they have the following:

- severe bleeding after the abortion is complete
- bleeding that turns from dark red to bright red (fresh blood)
- increased abdominal pain and the abdomen feels tight
- no bleeding and abortion is not complete
- fever, chills, abdominal pain, and bleeding

2.18 COUNSELING VICTIMS OF RAPE/SEXUAL ASSAULT

Rape/sexual assault is a crime in which a person is forced to have sexual intercourse without giving consent. Forced sex is intended to abuse, humiliate, and dehumanize the victim. Females, males, and transgenders (TG) may be victims of rape. Most do not report the rape because of shame, fear of revenge or rejection, and realistic fears about how they will be treated by the police, including the risk of sexual abuse. If an HRG client decides to make a formal complaint, the counselor should make sure he or she is always accompanied to prevent abuse.

➔ Avahan clinic programs should be working with local police to increase police support and decrease abusive practices.

Being raped/sexually assaulted/forced to have sex is a very distressing experience with long-

lasting effects. Every person reacts differently, and it is not unusual for feelings to change from day to day. In some cases there may be a long gap between the assault and the emotional reaction. HRG clients may need long-term counseling and support.

Psychological effects of sexual violence include:

- fright or severe anxiety
- guilt
- feelings of powerlessness
- anger
- shame
- depression
- numbness
- poor self-confidence

Apart from the psychological effects, victims may also have physical injuries or conditions such as:

- bruises, scratches, cuts, broken bones or internal injuries from beatings
- swelling or bruising around the genital, anal, or oral area
- sexually transmitted infections (such as herpes, gonorrhea, HIV/AIDS, and syphilis)
- possible pregnancy

Victims require professional counseling and medical care to prevent pregnancy and STI as a result of rape. Referral resources should include services that can provide sensitive care to male/female/TG victims of rape or sexual abuse.

Counselors need to be aware that some TG clients may feel that being abused by their partner means that they are really a "wife," due to widespread perception that beating is a husband's right and an expected part of marriage.

Establishing, Managing, and Using a Referral Network

SECTION THREE

Photo: Anita Khemka

3.1 ESTABLISHING AND MAINTAINING A NETWORK OF REFERRAL RESOURCES

Clients will have needs that cannot be directly provided for by the Avahan Clinic and outreach program. Many services will need to be provided through referral agreements with other providers who are not a part of the Avahan program. Each clinic, program staff, or state-led partner (SLP) staff will identify potential services and resources that can provide additional assistance to HRG clients and negotiate agreements to allow for referrals. Referral services or resources may be private, NGO/CBO, faith-based, or government. The relevant staff should select services that are likely to provide a positive experience for HRG clients.

The agencies participating in the referral network will need to agree on what a client can expect from the referral agency, the process of making a referral, the format of a referral form, and whether the receiving agency will keep any data regarding people who seek services based on the referrals. The agreement may also state any limitations — for example, the agreement may identify specific clinic staff who have the authority to make a referral.

Staff and managers of services who have not worked with marginalized groups may need special orientation so that they feel comfortable and confident working with HRG clients.

Some common referral needs are as follows:

- STI treatment and other medical treatment services
- ICTC (integrated counseling and testing center)
- other HIV-related, antiretroviral therapy (ART) center, and care and support services
- tuberculosis screening, diagnosis, and treatment services
- partner counseling and referral services
- reproductive health services, including family planning, PPTCT, and antenatal care
- drug or alcohol dependence and de-addiction facilities
- mental health services
- legal services
- assistance with ration cards and other documentation, such as birth registration
- other support services: housing, food, employment, transportation, child care, domestic violence assistance

The referral agencies/services are to be documented in a directory of referral services. This directory will list the service, location/s, service hours, who may use the service (criteria), any costs, and any other information that is needed by the counselor or the client.

Appropriate clinic staff will maintain working relationships with the managers of services in the referral network to ensure referrals can continue smoothly. This may be done formally through regular meetings held to discuss and solve problems, or informally through phone calls or visits.

3.2 MAKING EFFECTIVE REFERRALS

To make effective referrals, counselors will need to do the following:

- Work with HRG clients to determine their priority needs.
- Explain which needs can be met by the Avahan project and which will need outside resources. Explain the referral system and how it works.
- Outline the health, social service, and other options available that best match the client's need and help the client choose the most suitable in terms of distance, cost, culture, language, gender, sexual orientation, and age.
- Consult with the HRG client to identify any reasons the client may find it difficult to complete the referral and address these issues.
  - Examples include lack of transportation or child care, work schedule, cost, and fear that providers will be rude.
- Discuss shared confidentiality with clients: explain how the referral is made and what information will/will not be given to the agency to which they are being referred.
- Get the client's consent for sharing confidential information that is needed for making a referral.
- Offer to have the client accompanied if the client chooses and arrange for this with PEs or other volunteers.
- Make a note of the referral and any consent in the client's clinic record.
  - Ensure follow up and monitor the referral uptake if the clinic has a monitoring agreement with the referral resource.
- Document the referral in the organization's referral register.
- Follow up during the next visit: Ask the client to give feedback on the usefulness and quality of services to which he or she was referred. Plan next steps.

3.3 TOOLS TO FACILITATE THE REFERRAL PROCESS

The Avahan project does not have standardized data or record forms. Each clinic or implementing agency (IA) may develop their own forms and tools. These may include a directory of referral services, referral forms, and referral registers. Ideally, tools will be developed in consultation with the referral network/ resource agencies in order to maintain accuracy, efficiency, and consistency.

Any form or tool developed should include instructions that describe how the tool is designed to be used.

The referral tools may include:

- directory of services (and data collection and update form)
- referral form
- HRG client's personal clinic record
- referral registers
- a record of any monitoring data received back from referral services

Ethical Standards

SECTION FOUR

Photo: Anita Khemka

Each clinic should have a written code of ethics that each staff member and volunteer must know. If a code of ethics does not exist, counselors should propose preparing one to their management.

A code of ethics may have more than one component. One part may set out the clinic or organization's ideals, such as the rights of clients receiving services. A code of ethics may cover expectations such as the following:

- HRG clients have a right to know any information that relates to them, including what is in their records.
- No HRG client can be denied any treatment or care services that she/he is eligible for in the STI clinic unless there has been repeated documented abuse of the services.
- Every HRG client, irrespective of economic, social, or other differences, is to be treated with respect at all times by all team members.
- No physical or mental harm should be inflicted on any HRG client.
- All policies and procedures regarding confidentiality will be followed.

The second part of the code may be used to describe the rules to be followed by staff and volunteers; this is sometimes called a code of conduct. Items in the code of conduct should be stated as actions that can be defined and observed. Examples are "no drinking alcohol or using drugs while on the job," or "no personal relationships with HRG clients."

4.1 CONFIDENTIALITY

Counselors are to keep all information shared by the HRG client confidential, with the exception of information that falls under "shared confidentiality." This information may include a sexual history or other information needed by more than one staff member for the purpose of giving quality care. Counselors will explain this to each HRG client during the first visit and will remind a client when specific confidentiality issues come up during counseling.

As discussed in Section 3, Referrals, the counselor will explain what information will be shared with referral services, and obtain and document the HRG client's permission for this.

If the counselor feels that the client would benefit from the help of a PE or other project volunteer, such as having the volunteer accompany the client on a referral visit, the counselor must discuss this with the client and get permission to involve a volunteer.

A counselor may break confidentiality only on certain grounds. These are:

- if the HRG client may harm himself/herself
- if the HRG client may harm others intentionally

4.2 SEXUALITY, SEXUAL HEALTH, AND RIGHTS

Clinic counselors are expected to be knowledgeable and comfortable talking with HRG clients about all issues of sexuality. Counselors will need to make efforts to be aware of their own values and how these values affect their attitudes and ability to work non-judgmentally with HRG clients.

In every country, there are laws and regulations aimed at controlling sexual behavior. These may pertain to the type of sexual act, the age of the person, whether or not the sexual act is consensual, buying sex, selling sex, living off the proceeds of someone's selling sex, trafficking for sexual purposes, and so on.

Even when people are arrested for breaking laws, they still have rights, which are to be protected. Every clinic working with HRG clients should have access to legal advice and links to HRG support groups that are able to respond to arrest or harassment.

Counselors working with marginalized populations may find that ethical counseling practice conflicts with the law. A counselor should never feel alone in handling important, major decisions, especially in the case of an ethical or legal issue. These decisions should be referred to a supervisor or to management. Any issues or concerns should be discussed with a supervisor.

See Annex 3.1, Sexual Health and Rights.

Keeping Client Records

SECTION FIVE

Photo: FHI Aastha

5.1 DOCUMENTING COUNSELING SESSIONS

Each counselor is to maintain a record of counseling sessions, both group and individual. Individual counseling session notes are included in the client record. Counselors will also be expected to log data required for clinic monitoring and for case review and supervision purposes, as described in Section 8, Counseling Data Collection.

An example of a counseling service data collection form is provided in Annex 6.1, STI/HIV Counseling Service Data Collection Form/Register.

5.2 HRG CLIENT RECORDS

The purpose of the client record is to ensure that counselors and clinical staff are able to give quality care to HRG clients. The client record should be systematic, and follow a standard form designed by each clinic. This systematic record will be used by both counseling and clinical staff to maintain continuity of services. The client record will also contain records of clinical service; this part of the record is the responsibility of the doctor or nurse. Counselors will take responsibility for documenting each HRG client counseling session, using the form. Without a systematic recording system, it is unlikely that a counselor will remember all the details that the client has given or the plans that have been made with that client. The records are also a valuable resource during supervision/case review.

Counselors are responsible for making sure that the doctor/nurse who will see the HRG client receives any information collected from the client before seeing the doctor/nurse.[6] This means that some recording may need to be done more or less at the same time as the sexual history is being taken and other counseling topics are being covered. If this is done, counselors must take care not to turn the client record form into lists of items to be checked off as a substitute for interacting with the client. Counselors will need to explain to their HRG clients what is being written, and why and how the information will be protected.

Client Counseling Record Models

The following is one option for structuring a client counseling record. Another possible model is provided in the box below.
Client counseling notes for each session should include:

Objective Information: what was discussed, concerns expressed by the client, information

6 If the client comes for counseling only after seeing the doctor/nurse, these clinical staff will be responsible for completing the clinical part of the client record and sending this to the counselor.

relevant to care or risk reduction, decisions made, skills training given, referrals made, results of any previous referrals, action taken on plans or agreements such as risk reduction or partner notification plans, and the reported results.

If health education has been provided by other staff or volunteers in the clinic, the counselor should note what was covered.

Subjective Observations: The counselor may have noticed, for example, that the client seemed depressed or angry, seemed to be avoiding something, or was under the influence of alcohol or drugs.

Action/plan: Describe plans for any steps the client will take between this visit and the next — for example, risk reduction trial, talking with a partner, or making use of a referral. These are steps to be followed up during the next session.

The counselor should also include any signed consent forms or documentation of any verbal agreements, such as arrangements for help from a PE.

Management of HRG Records

All client records are to be kept in a locked file or cabinet. The key is to be held by the counselor or a designated person who is responsible for ensuring that the records are kept confidential and that they are available to counseling and medical staff when needed.

CLIENT RECORD INFORMATION COULD ALSO BE RECORDED UNDER SPECIFIC TOPICS.

At a minimum, the objective documentation relevant to counseling should include

- sexual history, to be updated as needed at each visit by the counselor (This may also be done by the doctor or other clinical staff.)
- checklist: topics covered in each counseling or health education session by either a counselor or someone else in the clinic
- risk reduction plans: review of action and updated planning
- referrals made and follow-up on referrals
- any verbal agreements made with the HRG client about sharing of information
- copies of the client's signed informed consent
  - › to share specific information with referral agencies
  - › for HIV testing
  - › for sharing of any confidential information aside from the information that is shared with other clinic staff for reasons of client care (This shared confidentiality must be explained to the client during the first visit.)

Client records are to be taken from the files only by the person who has been assigned as responsible. The HRG client record is given to the counselor if he or she is talking to the client before the client sees the doctor/nurse, or to the doctor/nurse if either of them are seeing the client before the counseling session.

Clerical staff may handle files if HRG client flow requires this; however, they should be instructed that files are confidential and must be kept closed. Supervisors are responsible for making sure these instructions are followed.

At the end of the clinic day, all records must be returned to the locked file/cabinet and not left on desks or in/out trays. Records must never be left where they can be picked up by unauthorized persons.

Counselor Supervision and Support

SECTION SIX

Photo: Tita Oronoz

6.1 REVIEWING AND SUPPORTING COUNSELORS

Supervision

In the Avahan project, there will be at least two levels of supervision. The first is the supervision provided on a day-to-day basis in the clinic, by clinic managers. Second, the SLP responsible for the clinic services will also be making supervisory visits. Ideally, the SLP supervision and support team will include an experienced counselor.

Counselors may be faced with many challenging HRG clients and their difficult situations. Immediate supervisors, who are the main source of staff support, may not have any expertise in counseling on such occasions. Each clinic should seek to identify a source of backup counselors as well as qualified consultants in counseling who can provide support and capacity building, as well as prevent burnout of counselors.

Clinic managers and supervisors should ensure that ethical issues such as confidentiality are being adhered to by counselors and staff providing health education.

Supervisors should monitor counselors for signs of burnout so that appropriate measures can be taken.

See Annex 5.1, Preventing and Managing Counselor Burnout.

Site Visits by SLP Counseling Supervisors

Site visits by a person qualified to provide supportive supervision to counselors are essential. The visit is to be arranged in advance, in consultation with the clinic manager and the counselor. The supervisor is responsible for explaining the process of the supervisory visit and what preparations the counselor is expected to make. For example, if the supervisor will be observing a session, the counselor will need to get permission from the HRG client in advance. All supervision and monitoring tools should be shared in advance with the counselors, who should be encouraged to assess their own performance during supervision. Supervision feedback must be constructive, with the aim of improving the quality of counseling. The counselor will be involved in making plans for improvements. If the solution to a problem is outside of the counselor's authority, the supervisor will discuss this with clinic management.

See Annex 4.1, Supervision and Support for Counselors, which includes a Counselor Self Assessment tool.

Case Studies

All counselors should maintain a diary where they make note of interesting or challenging cases or situations they'd like to discuss with their supervisor. Case studies may be shared with other counselors, without divulging the name of the client.

The supervisor is to review selected client records and facilitate a discussion of case studies during counselor supervision, or in team meetings or review meetings when relevant. This should be done on a weekly or monthly basis, preferably by the supervisor, with backup by a counseling consultant when available.

Verbatim Reports

These reports are very helpful when there is a counseling supervisor. The counselor takes detailed notes about the session, which will help the counselor study the session later and determine what he or she could have done better; a counseling supervisor can advise the counselor on how the counselor could have handled the session differently. The report can be written only after the session is finished; the counselor will need to rely on brief notes and memory. During a session, counselors should focus on the client rather than on writing.

Review Meetings/Team Meetings

Every clinic is expected to hold weekly and/or monthly review meetings during which the issues of the STI clinic are discussed and decisions are made to improve the quality of the services. The meetings are also used for work planning purposes. Case presentations may be made as part of the review meetings, particularly when a case raises care issues relevant to clinical, counseling, and outreach staff.

Preventing and Mananging Counselor Burnout

SECTION SEVEN

Photo: Shaju John

7.1 DEALING WITH COUNSELOR BURNOUT AND OCCUPATIONAL STRESS

"Burnout" is a term used to describe a range of symptoms. It can be a response to emotional strain over a period of time among individuals who work or care for individuals, families, or groups. A person suffering from burnout will generally have more than one symptom:

- **physical symptoms** such as fatigue, sleeplessness, nervousness, tension, pain, and lack of appetite
- **psychological symptoms** in the form of depression, irritability, lack of motivation and drive, grief, and guilt
- **behavioral symptoms** such as staff conflict, inability to get work done, or problems at home

Different factors can lead to burnout, which is caused by a combination of the type and amount of stress and the ability of a counselor to deal with this stress. Each person will respond differently to the factors that can cause burnout because each will have different ways of thinking as well as different personal and external resources to draw on. An organization can contribute to or decrease the amount of stress in the work setting and to the resources a counselor has to help deal with stress.

All counselors and their supervisors need to be aware of and watchful for signs of burnout. It is often difficult for people suffering from burnout to recognize it themselves. Staff may feel it is shameful or weak and be reluctant to raise any personal concerns. It is the supervisor's responsibility to monitor the counseling staff so that early signs of burnout are identified and addressed.

Supervisors are also responsible for helping to prevent burnout, as much as possible. This may require advocacy with senior management on behalf of the counseling staff.

Examples of factors that may contribute to burnout for STI counselors include

- having unrealistically high expectations for self, clients, and the results of counseling
- trying to "fix" problems or clients, rather than accepting that clients will need to make their own decisions and take action — or not
- limited treatment options and poor resources for clients
- being stigmatized for working with diseases or populations that are stigmatized
- discomfort in dealing with sexual issues that may be counter to their own values
- becoming too personally involved with clients
- dealing with people with whom they are not comfortable, such as IDU, sex workers, MSM, and TG

- fear of HIV infection
- lack of appropriate supervisory support
- too many clients/too little time
- expectations of program for counseling not matching HRG client's perceived needs
- inadequate training to meet expectations of the work
- working conditions: work overload, lack of privacy, space, hot/cold
- emotional exhaustion
- physical and psychological isolation: being the only counselor, having no opportunity to consult with counseling peers or more experienced counselors, supervisors who are not counselors not understanding the emotional loads
- inability to help clients find reasonable solutions, feelings of helplessness

See Annex 5.1, Preventing and Managing Counselor Burnout.

Counseling Data Collection

SECTION EIGHT

Photo: Anita Khemka

8.1 DAILY DATA COLLECTION, MONTHLY REPORTS

Every counselor will maintain a daily report of the work completed that day. A data collection form will be provided by the clinic management. At the end of the month, a summary report of all the sessions conducted over the month will be prepared and submitted to clinic management by the counselor. This report should include the number and sex of HRG clients counseled, number and focus of counseling sessions conducted, number of clients referred, and number of clients returning for follow-up.

See Annex 6.1, STI/HIV Counseling Service Data Collection Form/Register.

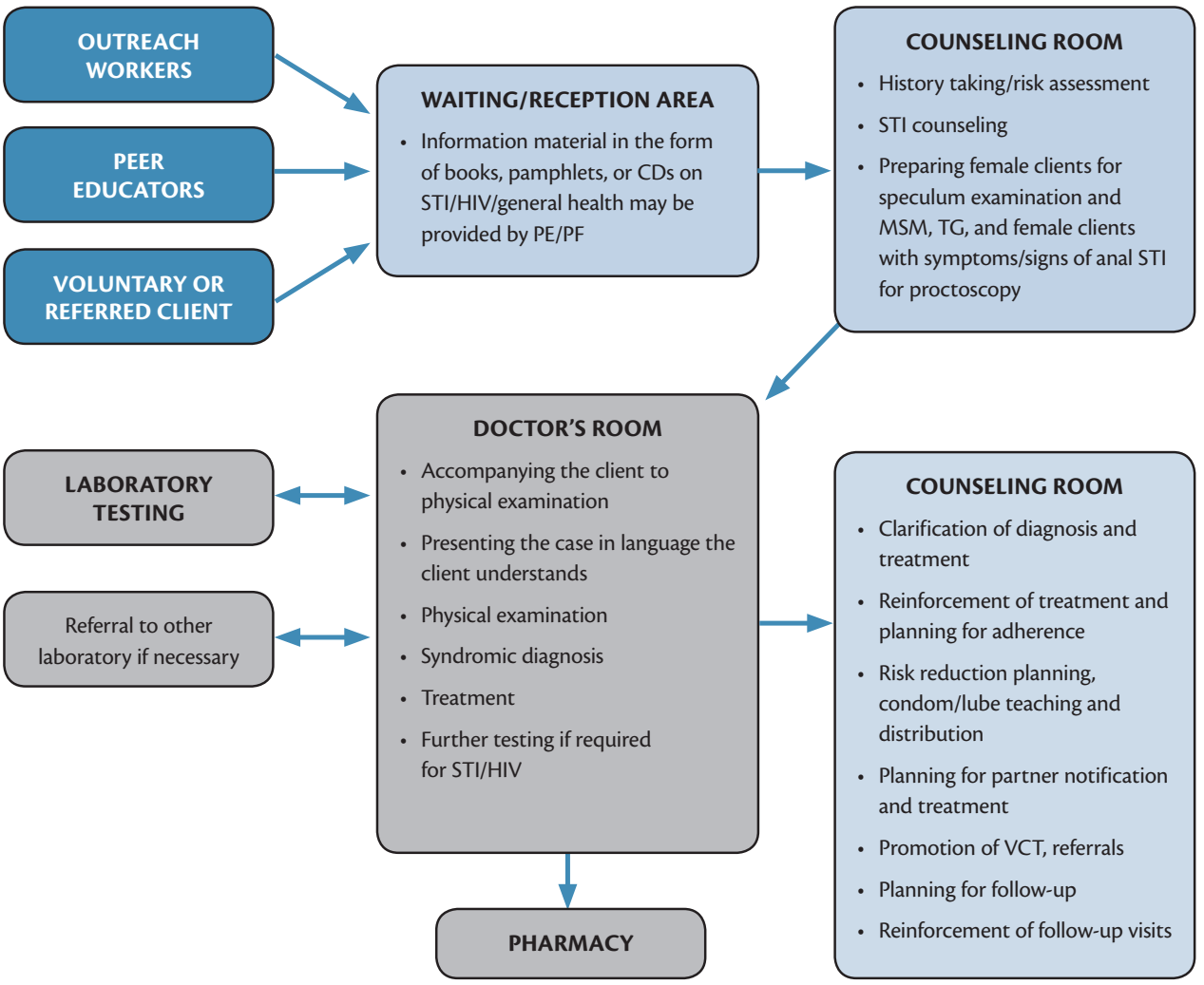
ANNEXES

Photo: Anita Khemka

Annex 1

1.1 Operational Flowchart

The following operational flowchart is from the *Operational Guidelines for Avahan-Supported Clinics Providing RTI/STI Services in India*. It is provided for illustrative purposes, and can be adapted to local conditions and included in the Operational Manual.



Annex 2

2.1 Understanding Your Clients

FEMALE SEX WORKERS OR WOMEN WHO HAVE MULTIPLE SEX PARTNERS

Female sex workers or women with multiple sex partners may or may not identify themselves as sex workers. As always, it is best not to label anyone unless the client herself uses a label.

Women will have different relationships with different partners, and these different relationships will have different values or meanings to them. The values or meanings of a relationship will affect their willingness and ability to make changes in how they have sex with these partners. The same will be true of male HRG clients.

For example:

- Some partners may be taken only for financial or other material benefit.
- Some partners may be taken for financial benefit, but with a degree of personal intimacy due to a more extended relationship, such as with boyfriends and regular clients.
- Some partners may be more important for the intimacy involved such as lovers, boyfriends, and others. This doesn't mean that there cannot be material or financial gain involved as well but this is not how the relationship is primarily viewed. However, the financial gain may be acknowledged and the relationship may not continue if there is no support from the partner.
- The woman may be supporting her partner through her work. The partner knows, accepts, and may even encourage or help her to find clients.
- A woman may have a husband and family who may or may not know of her sex work.
- Many female clients will have children; the father may or may not be present.
- Most female clients will desire one or more children.
- Women may be forced to have sex. This is rape whether or not your client has a prior sexual relationship with the person.
- Clients may have sex due to coercion — that is, threats of negative consequences if the client doesn't agree.

COUNSELING FEMALE SEX WORKERS OR WOMEN WHO HAVE MULTIPLE SEX PARTNERS	
Issues	**Points to consider in counseling**
Many of the women the counselors will see do not identify themselves as "sex workers" for a variety of reasons. Some are married women, whose husbands may or may not know of their other partners (paying or otherwise). Others have boyfriends who contribute in different ways to their lives. These women and their boyfriends may or may not have other partners at the same time. Some are "sequentially faithful."	Be very careful when using labels that may be offensive to the HRG clients. Ultimately it isn't the label that is the source of vulnerability, it is the behavior. The client may find it difficult to consider that her boyfriend/partner may have other partners. In such cases, talking about the time "before you got together" may provide an opening for discussing risk. Some women may have multiple "transactional sex" partners. These relationships include an expectation that some sort of assistance will be given. Assistance may be tangible, such as rent or housing, clothing, food, or help with school fees. Other benefits may be intangible, such as status or protection.
The more intimate the relationship, the less likely the couple will be using condoms regularly. A sex worker is more likely to consider using condoms with a "one-time" client, less with a regular client, and even less with a regular partner.	Do not assume that all partners are the same or that safer sex/condom use issues are the same for each partner. With some of the client's partners, the main focus is money. With more regular partners, issues of trust and need for intimacy begin to take precedence. The counselor will need to help the HRG client find ways to view and present condoms/safer sex to regular clients and partners as a way of showing love or caring for each other.
Difficulty in negotiating safer sex especially in time of need and if client pays more for unprotected sex	Women will need assertiveness and negotiation skills. If the project is doing self-help group development or has referral agreements with income or livelihood projects, make a referral.
Risk of violence from police, "goons," clients, and regular partners	Teach skills in sensing potentially violent clients and how to avoid them. Assist sex workers in exploring ways to earn extra income and refuse unsafe clients. Increase community involvement. Document structural violence within the monitoring and evaluation system for advocacy purposes.

COUNSELING FEMALE SEX WORKERS OR WOMEN WHO HAVE MULTIPLE SEX PARTNERS	
Issues	**Points to consider in counseling**
Some HRG clients use drugs or alcohol to decrease negative feelings. Some may need to drink as part of entertaining their clients. Female drug users are often partners of male IDU and may be selling sex to support the drug habits of both.	When counseling clients on safer sex, explore their use of drugs and how this might put them at risk. Discuss ways to reduce risk. This may involve limiting the amount of drugs taken or having a plan to avoid sex or practice safer sex when using drugs.
Poor compliance with STI treatment due to work-related alcohol intake and interaction with metronidazole	Develop a plan and schedule for the best time to take STI medication (e.g., metronidazole is best taken prior to sleeping and is very likely to cause severe nausea if taken within 24 hrs. of drinking alcohol).
Client has difficulty notifying partners.	Focus on partner notification with regular partners. Identify options and rehearse to build confidence. Link with field staff for assistance.
Some sex workers are not allowed to access STI clinics.	Work with implementing partner staff on advocacy with middlemen/pimps/managers. Provide outreach clinic services and refer clients to clinic for follow-up services.
Client refuses speculum examination.	Explain reason for internal exam, show speculum, and use pictures to show how it is used. Allow client to handle the speculum. Work with PE/PF so they can communicate about their own experience with the examination.
Recurrent STI	Explore with HRG client reasons she may be getting recurrent STI. Explore the barriers for prevention. Work on barriers one at a time through risk reduction planning. Link the negative long-term effects of STI with something she values to increase motivation.
Regular partner issues	Work with IP to create “male sexual health” activities that are appealing to regular partners. It may be best to have these activities as ”men only,” as a man may be the regular partner of more than one HRG client/sex worker and may not want to be identified as anyone’s partner.

MEN WHO HAVE SEX WITH MEN (MSM)

Counselors will often hear the term MSM or men who have sex with men. The term is meant to describe a specific behavior, not as an identity for any specific population group. The act of having sex with another male does not mean your client will include that in his sexual identity.

"Homosexual" is a biological term. It means "same sex," whether female/female or male/male, though most people think first of male/male sex. Many men who think of themselves as heterosexual may have sex with another male for a variety of reasons. A man may not consider what he did with another male as "sex." Your clinic may also serve transgendered persons, those who are born with a male body and genitalia but identify themselves as female.

The term "gay" is a Western term that can be used to refer to males who have a sexual or intimacy preference for males, and females who have a sexual or intimacy preference for females. It is often used as a self-identity. In South Asia, "gay" is generally used as a self or group identity by middle/upper economic class or educated/urban MSM.

Counselors need to be careful of labeling and making assumptions about any male who has sex with another male. Sexual self-identities[7] vary widely in South Asia. There are many different terms in different languages that are used to label people. Take the lead from your clients: ask them how they think of themselves and how they would prefer to be addressed. Use whatever term they feel comfortable with.

DEFINITIONS OF ROLES IN SEX

Penetrative sex: the penis is put into a partner's anus, mouth, or vagina during sex

Active or insertive partner: the partner who puts his penis into a partner's anus, mouth, or vagina

Passive or receptive partner: the partner who receives the partner's penis into his or her anus, mouth, or vagina

Counselors should keep in mind that same-sex activity is both stigmatized and illegal in India (IPC Sec 377). However, once a counselor has gained the trust of an HRG client, frank discussion should not be a problem.

Never make assumptions about any MSM. Counselors need to keep in mind that many of these males will also have sexual relationships with women, regardless of sexual identity or preference. Due to cultural expectations, many will marry in order to keep their secret.[8] Different populations may have their own networks. Each network may or may not have interaction with other networks or groups of MSM. Those who are most guarded may not be part of a larger network.

Often what influences how a male identifies himself sexually is the role he takes within sexual relationships. Sexuality and sexual identity may influence vulnerability and risk.

7 A person's sexual identity is how he or she thinks about him or herself as a sexual being.

8 Counselors interested in understanding more about male sexuality in India can talk with staff and PE of programs working with male groups or see www.nazfoundationinternational.org and www.humsafar.org for extensive information from two organizations run by and for men who have sex with men in India and South Asia.

Counselors will need to find out whether a client takes the active or passive role during penetrative sex. Receptive partners, especially during anal sex, are at higher risk of infection. One reason for this is that the anus is less "stretchy" and does not lubricate itself, unlike the vagina. Small injuries are more likely.

Self identity as a heterosexual, or as a manly or "real man," may depend on being the person who penetrates, regardless of the sex of the partner. Men who take this role are likely to consider themselves heterosexual, and their partners may think of them as "real men." These men are acceptable sexual partners among men who have a more feminine identity.

The sexual self identity of the passive male partner is likely to be more feminine, based on the gender expectation that females play the passive role in sexual activity. Some men will alternate roles.

MALE SEX WORKERS (MSW)

Male sex workers' sexual self identity, preferences, and practices will vary. Male sex workers may or may not have a sexual preference for other males. Many may have sex with males only for the money, while their personal sexual preference is for female partners. They may be married. These male sex workers can be very difficult to reach as they have a strong need to keep their sexual practices secret from their family and community. They may not be part of any particular network of male sex workers.

Others male sex workers may be attracted to both men and women. Their clients will be male and their personal relationships may be with men or with women. Some MSW will feel a strong preference for male partners, taking male clients and having male regular partners.

Their sexual or gender identity may vary depending on circumstances. Some may be selling sex to either or both men and women, regardless of personal preferences. Male sex workers will have regular and one-time clients, similar to female sex workers. The issues of intimacy and trust with regular partners are also similar to those of females.

Male sex workers' practices will vary also: some may perform only oral sex; others may give or receive anal sex.

Regardless of their identity, preference, and practice, many, if not most, male sex workers will be married or expected by their families to marry. Cultural pressure for marriage and reproduction, and the stigma of homosexuality, are so strong that most will marry and have children.

Male sex worker or MSM clients may have more casual partners than many female HRG clients. "Casual partners" refers to partners with whom the client has sex based on feelings of attraction, sexual drive, perceived need for sexual release, and other reasons. Payment is not the important factor in these relationships.

MSW/MSMs' appearance and behavior can vary by location and milieu. If they are working and dependent on attracting a client in a public space, they may adopt more feminine behaviors and dress. In other settings, where people are not to "know," they will behave as is culturally expected of boys or men.

For many of these men, maintaining secrecy from family and wives is essential, which can make it harder to reach them and harder for them to deal with partner treatment and notification.

TRANSGENDERED HRG CLIENTS — ARAVANI OR HIJRA

In South Asia, groups of transgenders with a long cultural tradition are usually referred to as Hijra. "Aravani" is a polite term and it may be preferable to using Hijra for many transgender clients. It is also appropriate to address and refer to your Aravani clients using feminine forms.

Speaking non-judgmentally, respectfully, and with kindness is essential. These clients have lived with great stigma and discrimination and are quick to pick up on negative attitudes, regardless of what words are spoken. One client who feels stigmatized can quickly spread the word through her network, and it will be very difficult to change this negative perception.

However, Aravani can be eager to help educate others about their lives. If counselors ask for help so they can understand something better, and explain why they are asking questions, their clients may prove very open and helpful.

Aravani have strong networks, and are not part of the same networks as other MSW/MSM. There may be more than one network in an area, and these networks may or may not have cooperative relationships. Each network is headed by a "guru." Counselors can best learn to understand their clients by spending time with them and the groups that are working with and for them.

Unlike MSM or MSW, Aravani will very rarely be living with family and will have adopted their Aravani community as their family. Aravani are constrained by having few economic choices in India. Traditionally, Aravani can earn by begging for alms, asking for donations from shopkeepers, or receiving payment for blessings at events such as the birth of a child. As this does not generate enough income to live on, many Aravani also sell sex.

Aravani are nearly all born biological males. They have male sexual organs and secondary sex and body characteristics (e.g., facial and body hair, deeper voice, male bone structure).

The amount of effort toward and success at making physical changes toward being a woman will vary. The most common practice in India is use of female hormones, usually oral, taken without guidance from a knowledgeable doctor.

Some TG may have surgery to remove the penis and testicles. This is a very personal decision and can be very expensive. Because of the cost, it is often done by untrained doctors or even "quacks," resulting in serious infections, pain, and illness. Clinics working with TG HRG clients should have at least one doctor who is knowledgeable and sympathetic as a referral resource.

The client's body changes are a common reason for fear of being examined by a doctor. This will need to be assessed as sensitively as possible if the counselor is to reassure the HRG client.

The counselor should always explain why questions are being asked and how the information will be used. This is particularly

important when asking questions about sexual activity and any efforts to increase femininity. Counselors should counsel about using sterile needles/syringes if hormones are being injected and the need for sterility in any clinical procedures.

A TG client may have many questions a counselor is not qualified to answer. Counselors should carefully explain their limitations and make appropriate referrals.

Basic information to share with your client includes:

- Hormones give no protection against any infection or disease.
- The feminizing effects of hormones will vary from person to person.
- The maximum physical effects of hormones may not be evident until after two years of continuous treatment.
- Biology limits the way the body will respond to hormones, and this cannot be overcome by increasing dosage.
- Sterile needles/syringes and safe injecting practices are essential.

MALE CLIENTS OF SEX WORKERS, MALE PARTNERS OF FEMALE SEX WORKERS

Counselors working in clinics serving truck driver populations will be seeing male clients. Counselors in other clinics may be seeing male partners of their clients or other men from their communities.

Counselors will need to ask these men about all sex partners, without using labels aside from male, female, and transgender (counselors may need to explain this label or use a more commonly known term). Counselors should not use terms such as "homosexual" or "gay,"' as these are likely to create denial and may offend the client.

If sex with male partners is denied, a counselor should explain that this is being asked because many men will sometimes have sex with a male or transgender partner when other partners are not available, or for variety. This may help the client open up. If not, the counselor should accept whatever he has said and focus on anal sex instead, without specifying the sex of a partner.

Follow-up will be nearly impossible with mobile HRG clients such as truck drivers. Counselors need to work closely with peer educators and outreach workers to make sure that appropriate health education is being given during whatever contact time is possible.

It's particularly important for counselors to identify common misconceptions relating to STI, HIV, and prevention, and to work with the outreach teams to counter these as the counselor may only meet with a truck driver once.

COUNSELING MEN WHO HAVE SEX WITH MEN	
Issues	**Points to consider in counseling**
Many men who engage in sexual activities with another male will not think of themselves as homosexual. Many males may be offended by this label as, in India, male-to-male sex is illegal and "homosexual" is perceived as stigmatizing. Using the label "homosexual" or asking about homosexual activities may not elicit the information needed for good counseling.	Never assume that an HRG client has sex only with the opposite sex. Ask whether the client's sexual partners are female, male, or both. Reassure that this is a question every client is asked. Give opportunities to talk about same-sex activities.
	Find out how to use laws against discrimination to provide services and protect people who have sex with people of the same sex.
Some men who have sex with another male may not view this as sex, but rather as playing, "discharge," or eliminating body heat/stress.	Ask whether the client's sexual partners are female, male, or both. Reassure that this is a question every client is asked.
Secrecy may lead to hurried and unprotected sexual encounters, increasing the risk of HIV transmission.	Explore barriers and help the client identify practical solutions. Make sure the client is confident about his ability to negotiate and use safer sex techniques. Make sure the client has adequate skills for using condoms in the settings where he is likely to have sex.
Guilt feelings about homosexual behavior may hinder men from being open and seeking help or benefiting from information relating to male/male sex.	Assure confidentiality and promote anonymity in providing services and information.
Fear of rejection or of being discovered by family, friends, and community often drives these men underground.	Assure confidentiality and promote anonymity. Practice non-judgmental attitudes and show acceptance.
Some men who prefer male partners are married because of the fear of social and family pressure, and fear of being found out.	Accept their fears and limitations. Explore options for safer sex practices with the client's wife or with all partners except the wife. Explore options for disclosure to the wife.

2.2 A First Counseling Session

Counselors should cover the following prior to the physical examination of the HRG client:

- Welcome the client and explain what he or she can expect during a clinic visit if this is the first.
- Explain the steps of the history-taking and physical examination, and assure that the clinician is male/female as appropriate.
- Take history, including present medical history, past history, obstetrical and gynecological history, sexual history, drug and alcohol use, and injections for any reason.
- Ask about family planning, intentions, and desires around having children (both male and female HRG clients).
- Promote acceptance of the speculum and/or anoscope examination.
- Explain about asymptomatic infection to both males and females.
- Explain the process after clinical examination.
- Explain why they need to wait, how long they may need to wait, and how they will know when it is their turn to see the doctor or nurse.

After the client sees the doctor or nurse, the counselors may:

- Review and explain the diagnosis.
- Reinforce the choice to come to the clinic for check-up or treatment of STI.
- Review medication with client:
  - how to take it
  - side effects and how to manage them
  - interactions with other drugs and alcohol
  - need to take full course of medicines and long-term effects of not treating STI
- Assess and resolve any problems the client may have with these instructions.
- Make a plan with the client to make sure he or she will be able to take all the medications as prescribed. Give a written reminder.
- Plan with clients for partner notification and treatment:
  - Refer to sexual history to identify partners who may need to be treated.
  - Reinforce the importance of partner treatment.
  - Help client choose best options.
  - Offer help of peer educator or outreach worker if needed.

- Work with HRG client to make a risk reduction plan:
  - Explain linkages between STI and HIV, and increased risk for HIV.
  - Assess the personal risk.
  - Assess the perception of risk.
  - Discuss options for risk reduction.
  - Plan on risk reduction.
- Work with the client to review and update the risk reduction plan:
  - Go over what was planned and what the client's experience was.
  - Point out and congratulate client on all positive achievements, including making an effort.
  - Help the client view any results as positive learning experiences.
  - Work to identify and prepare for next steps.
- Raise the possibility of having an HIV test and explain why you are suggesting this.
- Make any referrals that are appropriate.
- Make an appointment for the next visit or any follow-up.

2.3 Sample Counseling Protocol

Note: This is one example for counseling a female client, giving approximate times. Counselors should refer to the counseling checklists when adapting this example.

Counseling to Be Given Before Visiting the Doctor (approx. 13 minutes)

Phase 1: Commencement and Orientation to the Session [2–4 minutes]	
Protocol	**Content**
Introduce yourself to the HRG client.	Namaste, my name is _____ . I'll be talking with you today about what brought you to the clinic. (Initial rapport building)
Describe your role as counselor.	My role as your counselor is to work together with you to identify your STI risks and to explore issues related to these risks.
Explain confidentiality.	I want you to know that what we are going to talk about today will be kept private. That means your personal information will be absolutely confidential and will not be discussed with anyone else.
Assess client's reason for coming to the clinic.	Could you start by telling me what brought you in today? If it is for STI: It sounds like you have STI risks/ concerns (list them) that we should talk about today.
If a client has come for a checkup or STI treatment, an outline of session content could be: • clarifying STI misconceptions • assessing risk • risk reduction • STI treatment-seeking behavior • partner notification • partner treatment • condom negotiation • condom demonstration	We will check whether or not you have an STI and if you do, you will be treated. We'll also be talking about preventing infections in the future and getting your partner treated.
Address immediate questions and concerns.	Before we go any further, do you have any concerns or questions you need to talk about right now?

Phase 2: Assessing STI Risk [6–7 minutes]	
Protocol	**Content**
Assess HRG client's level of concern about having STI.	Tell me why you feel you are at risk for STI.
Explore most recent risk behavior. • When? • With whom? • Under what circumstances?	Tell me a little about the last time you put yourself at risk. How long did you know this person? Had you been drinking at the time of this exposure?
Take the sexual history/risk assessment (see the checklist). Find out if risks are occurring regularly, occasionally, or due to an unusual incident: • exposure to risk: when, where, how • number of partners • type of partners • STI: specify whether the client has STI now, had it in last 3–12 months, or had it before that • number of regular and non-regular sexual partners • frequency of new/different partners • condom use with regular and non-regular sexual partners • risk triggers: alcohol, drugs, stress, loneliness, money	Let's look at how often these risk situations happen: • How many clients have you had in the last two weeks? • Do you have an Aadmi/husband? • How well do you know your partner? • How often do you use condoms? • With what partners are you more or less likely to use a condom? • How do you decide with which partners to use condoms?
Assess partner's risk: • concerns about HIV in partner/s • sexual history • partner risk triggers • nature of employment • living together or apart • whether partner has other sexual partners • knowledge of partner/s' HIV status • future plans with partner • STI in partner	Tell me about your concerns regarding your partner's risk. Has your partner had sex with anyone else?
Assess communication with partners.	What have you and your partner talked about concerning HIV/STI risk? Did you and your current partner decide to stop using condoms?
Summarize the client's situation and risk issues: • risk pattern • prioritize risk issues	Here's how I understand your situation concerning risks for STI (summarize the key issues provided by the client). There are several issues that affect your risk behavior (list specific behavioral, communication, and substance use issues). You have been able to protect yourself sometimes (list circumstances that help the client reduce risk). Is this how you see risk behavior? Are there other issues we need to talk about?

Phase 3: Preparing Client for Treatment [2 minutes]	
Protocol	**Content**
Tell the client about the procedure, and promote acceptance of an internal examination.	How are you feeling before going to see the doctor? The doctor may diagnose you with instruments that may be part of an internal examination because most STI are internal in women. Do you have any questions?
Escort the client to the doctor.	Please get your check-up from the doctor and then return to me. We will talk more about infections, medicine, and what you can do to prevent new infections.

Counseling to Be Given After Seeing the Doctor (approx. 17 minutes)	
Phase 4: Complete Treatment and Partner Notification [5–7 minutes]	
Protocol	**Content**
Refer to case paper for type of STI diagnosed and explain its severity and what might happen if it is not completely treated.	_____ is the STI you have been diagnosed with. The initial symptoms are _____ , but if they increase they can cause _____ .
Tell the client why treatment is necessary and explain the need to comply with it strictly.	Explain why it is important to receive the complete treatment. to avoid relapse: an infection can come back even more severely. This may affect your work. to avoid your partner getting infected with STI, and to avoid re-infection from a partner
Partner notification and partner treatment planning	Let's talk a minute about telling your partner about this STI. Let's identify partners you need to inform about your STI infection. It is important to tell your partner and make sure your partner gets treatment. (The client should agree to make sure her regular partner is treated at the project clinic.)

Phase 5: Exploring Safer Options for Reducing STI Risk for Self and Others [8–10 minutes]	
Protocol	**Content**
Explore any previous efforts to reduce risk of STI or HIV infection and how these worked.	
Identify obstacles to risk reduction, such as condom usage. Work with your client on safer sex choices and negotiation skills or make sure they get to work with a PE/PF on this.	In what situations or with which type of partners do you find it difficult to negotiate or ask for safer sex? Let's talk about how you might get a client/partner to use a condom. We think having good skills is very important.
Explore triggers and situations that increase the likelihood of high-risk behavior.	How does using alcohol affect your chances of having high-risk sex? (if applicable)
Assess condom skills and teach condom skills.	How well do condoms work for you? Tell me about times you have had problems using condoms. With which partners do you find it most difficult to use a condom? Would you like me to demonstrate for you the proper use of a condom? • on the penis model with hand • on the penis model orally • blindfolded Now, you practice …
Identify entire range of options for reducing risks.	Tell me, what would be easy for you to change and what would be more difficult for you. Why? You have some options for reducing your risk. (List various safe options for clients, e.g., condom use with all the partners.)
Summarize risk-reduction options or discussion.	It seems like you have identified several ways in which you are comfortable in reducing your risk. (List the options client has selected.) Can you think of any other ways?
If the client has ongoing risk, convey concern and urgency about the risks and ways to reduce them (as appropriate).	It seems that unless your risk behavior and the other issues we identified are addressed, you may be more vulnerable to being infected with HIV. Let's talk about the plan to reduce your risk.
Sum up the session.	Let's go over the issues we talked about in this session and the risk reduction plan we prepared. Also, let's set a date for follow-up.

2.4 Checklists and Tools for New HRG Clients

CHECKLIST 1: NEW HRG CLIENT FOR SCREENING

	Resources
☐ Give a quick overview of clinic procedures.	
☐ Explain presumptive treatment and testing for syphilis on first visit and every six months.	Annex 2.4, Checklist 6: Explaining the Syphilis Blood Test
☐ Take health/sexual history.	Annex 2.4, Checklist 3: Taking a Sexual History
☐ Explain and promote internal exam.	Annex 2.4 • Checklist 4: Explaining and Promoting a Pelvic Exam • Checklist 5: Explaining and Promoting a Rectal Exam For MSM and TG Clients
☐ Help HRG client plan for risk reduction.	Annex 2.6 • Checklist 10: Counseling for Risk Reduction Planning • More Information on Safer Sex • Table 7: Ways to Help HRG Clients With Worries About Condoms • Table 8: Choosing the Right Barrier Method
☐ Offer condoms and lube, and instructions for use.	Annex 2.6, Checklist 11: Helping HRG Clients Use Male Condoms Correctly
☐ Offer to answer any questions.	

CHECKLIST 2: NEW HRG CLIENT WITH SYMPTOMS

	Resources
☐ Assess problem.	
☐ Assess efforts to treat problem.	
☐ Give a quick overview of clinic procedures.	
☐ Explain shared confidentiality in the clinic.	
☐ Explain presumptive treatment and testing for syphilis on first visit and every six months.	
☐ Take health/sexual history.	Annex 2.4, Checklist 3: Taking a Sexual History
☐ Explain and promote internal exam.	Annex 2.4 • Checklist 4: Explaining and Promoting a Pelvic Exam • Checklist 5: Explaining and Promoting a Rectal Exam For MSM and TG Clients
☐ Offer to answer any questions.	
☐ Explain that additional counseling will be done after the client has seen the doctor or nurse.	

CHECKLIST 3: TAKING A SEXUAL HISTORY AND RISK ASSESSMENT

	Resources
☐ Introduce and explain the sexual history/risk history.	Annex 2.4 • Checklist 3: Taking a Sexual History • Tool: Assessing for Pregnancy
☐ Explain reason for asking the questions and get client's permission to continue.	
☐ Reassure as to confidentiality (explain shared confidentiality).	
☐ Ask about medicines being used. Explain that drugs, including certain medicines and alcohol, can mix and interact with prescription medicines, so it is important for the doctor to know about these.	
☐ Check on risk of transmission through drug use or drug-using partners.	Annex 2.9, Background Information for Counselors on Injecting Drug Use
For drug users: ☐ Check on intention to stop or reduce drug use. ☐ Check on concerns about infection though sharing injecting equipment and drug solutions.	
☐ Check on alcohol use.	
☐ Check on efforts to decrease or stop alcohol use.	
☐ Check on allergies to medicine.	
☐ Check on history of blood transfusions and exposure to possibly non-sterile invasive procedures, such as injections and tattoos.	
☐ Make sure you know who your HRG client is living with. ☐ Confirm marital status/living with husband/wife.	
☐ Assess wishes for pregnancy and use of family planning.	Section 2.16, Reproductive Health Counseling for HRG Clients
☐ Female: check on possibility of pregnancy.	Annex 2.4, Tool: Assessing for Pregnancy
☐ Ask about sexual partners.	
☐ Check on perceptions of "faithfulness" and risk with regular partner/s.	

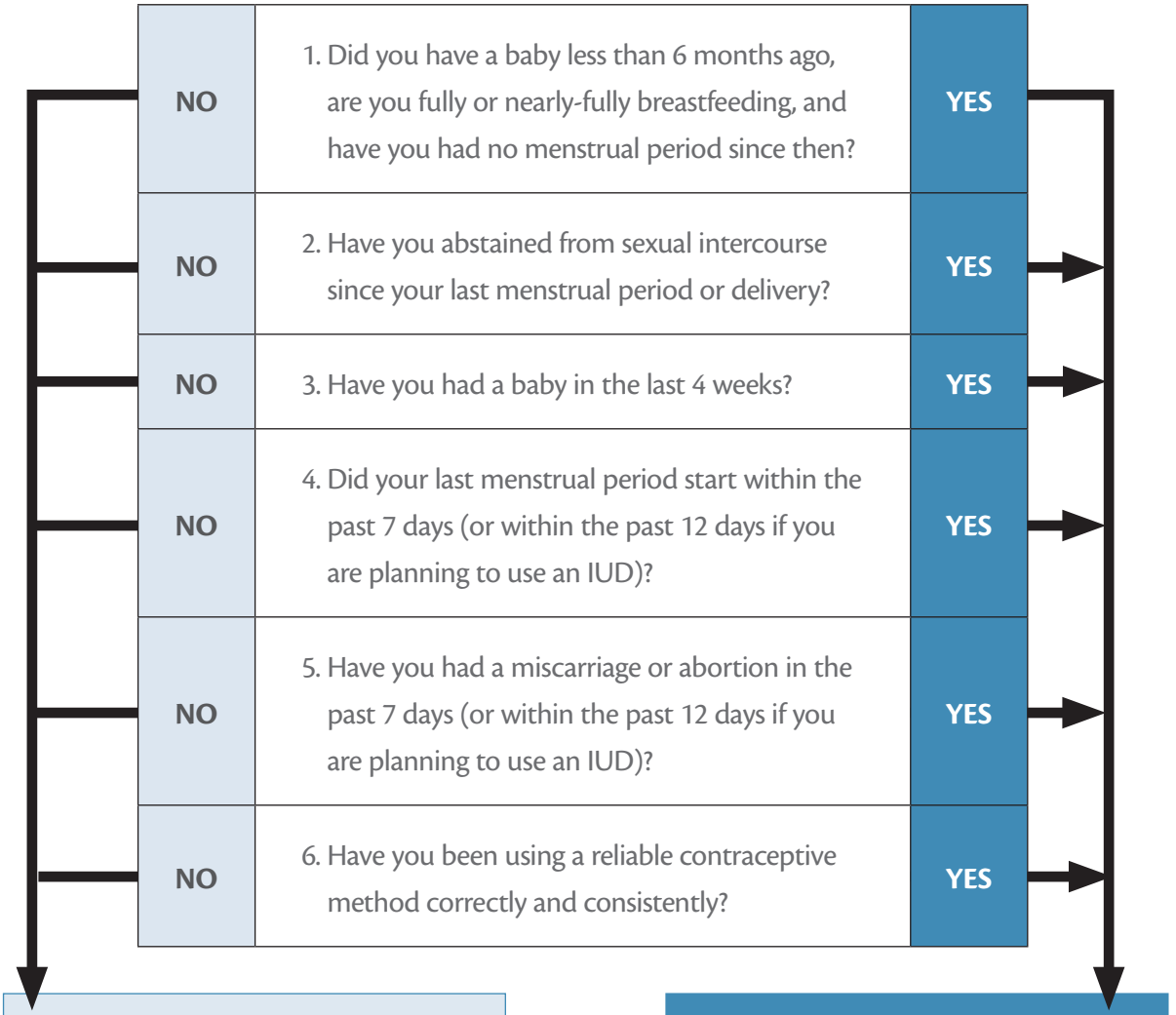
CHECKLIST 3: TAKING A SEXUAL HISTORY AND RISK ASSESSMENT CONTINUED

	Resources
☐ Ask about numbers of partners of each sex.	
☐ Ask specific questions about type of sex, as appropriate for the sex of the client you are talking with and the types of sex partners.	
☐ For all clients, assess level of concern about STI or bloodborne infections, including HIV.	
☐ Acknowledge any appropriate risk perception and assess prevention efforts.	
☐ Assess condom use and condom use barriers with different kinds of sex and sex partners.	Annex 2.6, Risk Reduction
☐ Discuss previous history of STI and link to current problem if client has come to the clinic because of STI symptoms.	
☐ Check on health-seeking practices for STI.	
☐ Check on history or partners having STI symptoms.	
☐ Ask about HIV testing. Assure your client you are not asking the result, only if the client has had an HIV test in the past.	
☐ Discuss any efforts toward increasing feminine sex characteristics with Hijra/Aravani HRG clients, including use of hormones and surgery.	Annex 2.1, Understanding Your Clients
☐ At the end of the sexual history, thank the client for his or her honesty. Acknowledge that it isn't always easy to have such personal questions asked. ☐ Check to see if the client has any questions or other issues to discuss.	
☐ Explain next steps at the clinic, including examination. ☐ Counseling after examination	
☐ For a patient identified at higher risk for STI, reinforce any efforts at prevention you have identified and lead into the risk reduction planning after seeing the doctor.	

TOOL: ASSESSING FOR PREGNANCY

How to be Reasonably Sure a Client is Not Pregnant

Ask the client questions 1–6. As soon as the client answers **YES** to ***any question***, stop, and follow the instructions.



If the client answered **NO** to ***all of the questions***, pregnancy cannot be ruled out. Clients should await menses or use a pregnancy test.

If the client answered **YES** to ***at least one of the questions***, and she is free of signs or symptoms of pregnancy, provide client with the desired method.

From: *How to Be Reasonably Sure a Client Is Not Pregnant,* Family Health International, Training and Reference Guides for Family Planning Screening Checklists (2008).

CHECKLIST 4: EXPLAINING AND PROMOTING A PELVIC EXAM

	Resources
☐ Introduce the topic of a pelvic or internal examination to the client.	
☐ Explain the reasons and benefits of pelvic examination if this is new to your female client.	
☐ Use pictures and a speculum (if available) to explain the examination. Encourage the client to handle the speculum.	Sample speculum
☐ Encourage the client to have an examination.	
☐ If the client is reluctant or refuses: Assess reasons for reluctance to have the exam and reassure or answer concerns.	
☐ If still undecided: Help client weigh benefits against the potential discomfort of a short exam.	
☐ For all clients who agree to be examined/new clients: Explain the steps of the examination.	
☐ Ask if there are any questions. Explain that the client will be seeing the counselor again after she sees the doctor.	
☐ Reinforce the decision to have the examination.	
☐ For a client who refuses, accept the decision and acknowledge her/his right to decide.	Annex 3.1, Sexual Health and Rights
☐ Assure the client that he or she will get to see the doctor anyway.	
☐ Reinforce the decision to come to the clinic.	

CHECKLIST 5: EXPLAINING AND PROMOTING A RECTAL EXAM FOR MSM AND TG CLIENTS

(Transgendered HRG clients should be addressed and referred to using feminine terms.)

	Resources
☐ Introduce the internal examination. ☐ Check on experience with the examination.	
☐ Explain the reason for the internal examination and potential benefits.	
☐ Explain the examination.	
☐ Use pictures and an anoscope (if available) to explain the examination. Encourage the client to hold the anoscope.	Anoscope Pictures of male internal anatomy
☐ Ask for and answer any questions.	
☐ If client is reluctant, ask for concerns and respond to these.	
☐ If client is still undecided, help client weigh the benefits of a healthy sex life against the potential discomfort of a short exam.	
☐ Reinforce decision to have examination.	
☐ If client declines, accept and affirm the client's right to make own decision, leave choice open for another time.	Annex 3.1, Sexual Health and Rights
☐ Assure the client that he or she can still see the doctor.	
☐ Reinforce the client's decision to come to the clinic.	

TABLE 6: ANSWERING QUESTIONS HRG CLIENTS MAY ASK ABOUT MEDICINES

How can free medicine be good medicine?

Many HRG clients may feel that free medicine cannot be good medicine. They may wonder why medicines are free from Avahan clinics. Inform them that:

- The medicine is free because it is paid for by the donor of the project. The reason is that STI are closely linked to HIV: it is easier for people who have STI to get or give HIV. STI also cause many health problems, even without HIV infection.
- The project is intended first to help people learn more about HIV and STI and how they can protect themselves from infection. The project is also to help people get STI treated correctly and quickly so they don't give the STI to someone else, so they don't have the health problems that come with untreated or incorrectly treated STI, and so they are less vulnerable to HIV or less likely to pass it on to a partner.
- The project also provides HIV testing and counseling so that people can learn if they have HIV and if they do, take steps so they won't give it to someone else, and also so they can learn how to protect their own health.
- The project is intended to help individuals, couples, and the community as a whole.

Why are the same drugs used for different infections?

The medicines that are used are the ones that have been proven to be the best treatment, based on research. These drugs meet international standards.

Infections that are caused by different germs may have the same signs and symptoms (things that can be seen/felt).

It is not always possible to tell exactly which of the likely germs is causing the specific signs/symptoms felt by the client and seen by the doctor. The only way to tell exactly may be laboratory tests that are expensive, take time, and can only be done in special laboratories or hospitals.

Since this isn't possible, the drugs chosen for you are chosen because they will kill the germs that are mostly likely to be causing the infection you have. It's also possible that you could have more than one infection, since they are "caught" the same way. Many people have more than one infection.

Why so many pills?

Research has shown how much of a drug is needed to cure specific problems. Sometimes it is possible to cure a problem by taking medicine all at one time. Sometimes pills only come with a small amount of the medicine in each one, so you will need to take a number of pills to get enough medicine to cure the problem.

continued

TABLE 6: ANSWERING QUESTIONS HRG CLIENTS MAY ASK ABOUT MEDICINES
Why do some of the medicines need to be taken so long? Some germs or infections are harder to cure completely than others. And sometimes the infection will have moved deeper into your body. In these cases, taking the medicine for one day or a few days may kill some of the germs, but not all of them. The infection can come back. It's also possible for the germs to develop resistance to a medicine. That is, the medicine can no longer kill this kind of germ or cure the infection it causes. This happens very often when people do not take enough to kill the infection completely. It has happened with many different drugs because of incorrect use by doctors, pharmacists, and clients. We can see examples with drugs such as penicillin or some penicillin-type drugs for urethral or vaginal discharge. They no longer work for these infections. Penicillin is still a good medicine to kill the germs that cause syphilis; this is why it's used. Having enough of the medicine in the body over a period of time is needed to make sure the drug can kill all of the germs.
Why not use more injections? Each medicine works best when given a certain way. Not all medicines can or should be given as injections. It is best to avoid any injections that are not needed and to use an injection only when it is the way the medicine will work best. Injections in the Avahan clinics are always given using sterile (new) needles and syringes, to make sure there is no risk that anyone will get an infection that can come from reusing needles/syringes. This is not always true in other settings.

CHECKLIST 6: EXPLAINING THE SYPHILIS BLOOD TEST

	Resources
☐ Explain the reasons for the blood test.	
☐ Make sure the client knows this is not an HIV test.	
☐ Explain when the test results will be available and how the client will know the results. This will depend on the procedures at your clinic. Some clinics will be able to do the lab work and the results can be available the same day. Others will be using outside labs.	
☐ Make an appointment for the client to return for results.	
☐ Remind client of what you talked about before with regard to the blood test.	
☐ Explain that the results of the test show that the client has syphilis and that he or she will be given medicine today that will cure it.	
☐ Continue with the counseling session.	
☐ Explain more about the stages of infection.	See COGS for more information.
☐ Explain that the client will get two different medicines to make sure the infection is completely cured.	
☐ Teach about side effects or reasons to contact a doctor.	
☐ Plan for risk reduction or review previous plan.	Annex 2.6, Checklist 10: Counseling for Risk Reduction Planning Previous plan from the client chart
☐ Offer condoms and check on ability to use them correctly.	Annex 2.6, Checklist 11: Helping HRG Clients Use Male Condoms Correctly
☐ Suggest and discuss an HIV test.	Annex 2.10, Checklist 20: Recommending an HIV Test to the HRG Client
☐ Make appointment for client to return.	
☐ Once again, reinforce decision to come for treatment.	

2.5 Checklists and Tools for Repeat HRG Clients

CHECKLIST 7: UPDATING HEALTH AND SEXUAL HISTORY FOR REPEAT HRG CLIENTS WITH NO SYMPTOMS

Review health and sexual history for updates of repeat HRG clients with no symptoms.

If the counselor is responsible for sexual/health history taking, this should be updated on every visit, regardless of whether a client is coming for screening or for symptoms.

	Resource
☐ Review the general health history and any key points on the sexual and reproductive health history:	HRG client record/history Annex 2.4, Checklist 3: Taking a Sexual History
☐ **For women,** ask about pregnancy, menstrual period, family planning method ☐ **For men** who have regular female partner, ask about family planning, pregnancy of partner	
☐ For all clients:	
☐ Ask if the client is taking any new medicines.	
☐ Assess any changes in drug or alcohol use.	
☐ Ask if there have been any changes in regular partners.	
☐ Review risk with any new regular partner/s.	
☐ Ask if there have been any other changes in partners: sex of partners, number, type of sex.	
☐ Review risk reduction plans and efforts as noted on chart and by questioning. Reinforce any positive efforts or steps.	Annex 2.6, Checklist 10: Counseling for Risk Reduction Planning
☐ Update risk reduction plan.	
☐ Summarize and confirm revised plan (make note in record).	

CHECKLIST 8: COUNSELING HRG CLIENTS COMING FOR REPEAT SCREENING — NO SYMPTOMS

	Resources
☐ Reinforce client's decision to come in for screening.	
☐ Review and update health/sexual history.	Section 2.6 Annex 2.4, Checklist 3: Taking a Sexual History
☐ Review and update risk reduction plan and offer condoms.	
☐ Check on any other concerns.	
☐ Remind of confidentiality.	
☐ Explain and promote an internal exam.	Annex 2.4 • Checklist 4: Explaining and Promoting a Pelvic Exam • Checklist 5: Explaining and Promoting a Rectal Exam For MSM and TG Clients
☐ Offer to answer any questions.	
☐ Additional counseling will be done after the client has seen the doctor or nurse.	

CHECKLIST 9: COUNSELING HRG CLIENTS WHEN IT HAS BEEN SIX MONTHS OR MORE SINCE CLIENT'S LAST VISIT

	Resources
☐ If it has been six months since the last visit, explain reasons for medicines being given (explain presumptive treatment).	Section 2.5, Explaining Syndromic and Presumptive STI Treatment
☐ Help the client take the medicine.	
☐ Explain the reason for the blood test.	Annex 2.4, Checklist 6: Explaining the Syphilis Blood Test
☐ Introduce partner notification/treatment.	Annex 2.8, Checklist 19: Helping HRG Clients With Partner Notification and Treatment
☐ Introduce risk reduction planning.	Annex 2.6, Checklist 10: Counseling for Risk Reduction Planning
☐ Plan for risk reduction or review previous plan.	
☐ Offer condoms and check on ability to use correctly.	Annex 2.6, Checklist 11: Helping HRG Clients Use Male Condoms Correctly
☐ Make appointment for client to return.	
☐ Get permission to have PE/HRG facilitator remind client of appointment. ☐ If appropriate, ask name of best person and make a note to follow up.	
☐ Once again, reinforce decision to come for treatment.	

2.6 Risk Reduction

CHECKLIST 10: COUNSELING FOR RISK REDUCTION PLANNING

	Resources
☐ Explain what this part of the session is for and get client's permission to continue.	
☐ Review client's current risk and feelings about risk. Ask if the client is concerned about getting an STI or HIV or giving an STI to a partner.	Section 2.6, Table 2: Practices and Risk: High, Low, Medium
☐ Check on level of concern.	
☐ Assess reasons for inaccurate perception of risk.	
☐ Correct any misconceptions client may have about infection.	
☐ If client is realistically concerned, discuss what client is doing about it or has already tried, and/or what client doesn't feel able to do.	
☐ Point out any other issues and discuss actions that might affect the client's risk, such as drinking and drugs.	
☐ Summarize discussion so far.	
☐ Help client think about benefits and costs of becoming infected with STI or HIV.	
☐ Find out if the client has tried anything that might decrease risk during sex.	
☐ Repeat back any steps and acknowledge any efforts with praise and acceptance. Check to make sure you've been understood.	
☐ Correct incorrect beliefs about reducing risk.	
☐ Ask if client would like to talk more about how he or she can reduce risk.	
☐ If client is willing, praise this willingness.	

CHECKLIST 10: COUNSELING FOR RISK REDUCTION PLANNING CONTINUED

	Resources
☐ Assess what situations or actions the client feels are most risky.	
☐ Help the client set a realistic goal for reducing risk.	
☐ Help the client think of a practical step for a given type of partner or situation. Confirm the step the client would like to consider.	Annex 2.6 • More Information on Safer Sex • Table 7: Ways to Help HRG Clients With Worries About Condoms • Table 8: Choosing the Right Barrier Method
☐ Help client break the change into practical steps. If appropriate, role-play discussion and negotiation.	
☐ If appropriate, offer to have client taught negotiation skills or condom-use skills.	Section 2.8
☐ Check on possible problems client might run into.	
☐ Check on possible support.	
☐ Summarize plan.	
☐ Propose HIV test and explain why.	Annex 2.10, Checklist 20: Recommending an HIV Test to Your HRG Client
☐ Continue with session.	

CHECKLIST 11: HELPING HRG CLIENTS USE MALE CONDOMS CORRECTLY

	Resources
☐ Make sure every HRG client is offered condoms and lubricant if your program has it.	
☐ Ask what problems the client is having with condoms and discuss solutions. Do condoms break or slip off? Are they not pleasurable? Do they cause loss of erection? ☐ [ask female client to report partners' problems with condoms]	
☐ If breaking is a problem, check for use of oil-based lubricants.	
☐ Make sure the client knows how to use a condom correctly. Ask the client to demonstrate the steps on the dildo/penis model as you go over them if you have not done this before. ☐ If client has never used a condom before, demonstrate first and then have the client demonstrate back.	List of steps in Section 2.7 Penis model, condoms

MORE INFORMATION ON SAFER SEX

Using Barriers to Reduce Risk During Penetrative Sex

A barrier is any device that prevents transmission of and contact with body fluids during sexual activity. To be effective, barriers need to be used correctly, every time, from beginning to end — before there is any sexual contact.

The section below describes how to counsel HRG clients about using barriers in addition to male condoms.

ORAL BARRIERS

During anal/oral sex or oral/vulva sex, clients should put lubricant directly on the person's body before using the barrier. Clients can use stretchy kitchen wrap as a barrier as this is readily available.

MALE CONDOMS

Most condom failure is from incorrect use. Make sure HRG clients have the skills they need to use condoms correctly in different situations, including with no light, and the ability to put a condom on very quickly or without a partner noticing.

Tell clients:

- They will need to check to make sure if the condom is still in place and intact if sex goes on a long time or is very active.
- They will need to use a new condom/glove/barrier if switching from anus to vagina.
- They will need to use care when removing and disposing of the condom/glove/oral barrier: use a tissue to avoid direct contact with fluids. If this isn't possible, wash hands immediately, before touching eyes, urethra, vagina, or mouth.
- Never use oily lubricants on barriers. Most are made of latex and the oil will make the latex break down. This is a common cause of condom breakage. Use water-based lubricant if available.
- For male condoms: clients can place a small amount of lubricant inside the tip of the condom before putting it on to increase sensation. Small = about the size of a pea. Too much lubricant can cause the condom to slip.

Other Safer Sex Tips

Explain to HRG clients that these actions can help prevent infections but are not a substitute for barriers during penetrative sex. Good hygiene can prevent other infections and skin irritation:

- Avoid sex during menstruation.
- Do a quick check of partner's genitals/anus to check for signs of STI (sores, swelling, discharge).
- Withdrawal before ejaculation may give some protection for the female partner.
- Withdrawal before ejaculation may give some protection for the receptive oral sex partner.
- Urinate after sex. This can help prevent local infections of the urethra, but not STI or HIV.
- Do not douche after sex. This can push germs up farther, through the vagina and

into the cervix. Also, some liquids used for douching are irritating to the membranes, causing tiny breaks.

- Wash the penis and under the foreskin (if not circumcised).

Prevent Trauma to Tissues and Increase Sensation

- Use water-based lubricant to prevent vaginal or anal trauma or irritation and to increase sensation.
- Do not use solutions or substances to dry or tighten the vagina as dry sex is very likely to damage tissues.
- Avoid using condoms with Nonoxynol 9 (a spermicide) as the chemicals on these can be harsh to the vagina, urethra, and rectum, causing irritation/tiny tears in the membranes that allow STI in.
- Make sure fingernails are short and clean.
- Remove rings/jewelry from hands before putting on a glove.

Reducing Risk During Anal Sex

- Use good quality condoms during anal intercourse.
- Use water-based lubricant with the condoms to decrease chance of condoms breaking and of injury to the rectum.

Reducing Risk During Oral Sex

Explain that using un-lubricated condoms for oral sex can prevent STI for both partners.

Clients should be advised to take care of the gums and skin of the mouth to keep this area healthy and free from bleeding. Partners are advised to postpone oral sex for several minutes following brushing or cleaning the teeth, as both can irritate the gums.

Reducing Risk by Having Non-penetrative Sex

Men or TG HRG clients having receptive anal sex may be able to give a partner "thigh sex" instead of allowing penetration. This can be done with or without the partner's knowledge.

It is done by pressing the thighs together to hold the penis during sex, using lubricant to make sex more pleasurable for the partner. This is most likely to be acceptable when the partner is not a regular partner.

Males who are receptive partners/TG can also hold their fist between their thighs to make a "vagina," reaching backward to take their partner's penis. If their hand is lubricated, the partner may not know the difference. This may also be a substitute for allowing anal penetration in some situations.

Masturbation

Bring a partner to ejaculation using hands. Any type of lubricant can be used.

TABLE 7: WAYS TO HELP HRG CLIENTS WITH WORRIES ABOUT CONDOMS

Client Concerns about Condoms	Helping with Concerns
They may come off and get lost in the vagina or body.	Use a picture of internal organs to explain why this is not possible.
Not possible to get pregnant	Explain that condoms protect from STI and HIV until ready for pregnancy.
Reduction in sexual pleasure	Recommend: • increasing sexual pleasure through foreplay • telling male partners that sex will last longer with a condom • using water-based lubricant to increase pleasure
Pain during sex	Suggest: • using foreplay to lubricate vagina to avoid dryness • using adequate water-based lubricant for anal sex or when vagina is dry
Condoms break during sex	Check on HRG client's actual experience with breakage: • Make sure client knows how to use a condom correctly. • Make sure client knows how to check the condom package for expiration date and the condition of the package. • Explain that rough or extended sex may cause condom to break.
Condoms have holes	Explain that good brand condoms are tested for quality, so they won't have holes. Also explain how to make sure the condom package is undamaged and the condom inside feels slippery (not dry).
Condoms only for multiple partners or paying partners	Explain that condoms protect their regular partner from any infections the HRG client may have gotten from other partners. They also protect the HRG client from any infections their partner/s may have. As part of risk reduction, help your HRG client decide how best to talk with a regular partner about risk within the relationship.
Costly and not locally available	Help HRG client get free condoms as well as add up the costs of getting sick with STI and losing work.
Embarrassing to buy condoms	Suggest buying condoms in small, discreet outlets or talking with PEs about getting condoms.
Condoms are too tight	Explain that condoms come in various sizes and are very stretchy. Show by making fists of both hands and putting the condom over both your fists.
Alternative condom	If female condoms are available/affordable, demonstrate and discuss these with your HRG client. Your PEs should be knowledgeable about female condoms and how to use them correctly if they are being distributed in your project.
If a condom breaks during sex	Instruct client to stop as soon as he or she notices a condom has broken and start again with a new condom.

TABLE 8: CHOOSING THE RIGHT BARRIER METHOD

	Hand	Mouth	Anus	Vulva	Vagina	Penis
Hand	X	X	Glove	Glove or plastic barrier (see oral barrier)	Glove	Condom or glove
Mouth	X	X	Oral barrier	Oral barrier	Oral barrier	Condom
Anus	Glove	Oral barrier	N/A	N/A	N/A	Condom
Vulva	Glove	Oral barrier	N/A	N/A	N/A	Condom
Vagina	Glove	Oral barrier	N/A	N/A	N/A	Condom

2.7 Checklists for Counseling on Specific STI Syndromes

The Avahan clinics will be treating HRG clients based on the syndromic and enhanced syndromic guidelines as specified in the COGS.

Counselors are responsible for making sure that HRG clients understand their diagnosis and treatment, and are assisted to take their medicine at the clinic or plan for taking medicine that will need to be taken over a period of days. Counselors also need to help HRG clients plan for risk reduction and for talking with a regular partner about the need for treatment.

It is advised that counselors raise the issue of having an HIV test and explain the reasons why this is being suggested.

Checklists are provided to match each of the possible syndromic diagnoses and treatment regimes. Some are for females, some for males/TG, and some for either sex/TG.

CHECKLIST 12: EXPLAINING TREATMENT FOR CERVICAL INFECTION (STI TREATMENT SPECULUM EXAMINATION)

	Resources
☐ Explain the diagnosis.	
☐ Explain how infections can be asymptomatic.	
☐ Explain causes of STI.	
☐ Explain why client is getting two different medicines.	
☐ Explain possible consequences of incomplete, incorrect, or no treatment and links between STI and HIV.	
☐ The doctor will have asked about allergies before prescribing the medicine. Check again about possible allergies to the medicine.	
☐ Help your client take the medicine.	
☐ Explain possible side effects of the medicine.	See COGS for more information.
☐ Introduce partner treatment. Check history for regular partner or ask client.	Annex 2.8, Checklist 19: Helping HRG Clients with Partner Notification and Treatment
☐ Introduce risk reduction planning. Carry out planning or review risk reduction planning.	Annex 2.6, Checklist 10: Counseling for Risk Reduction Planning
☐ Offer condoms and check on ability to use correctly.	Annex 2.6, Checklist 11: Helping HRG Clients Use Male Condoms Correctly
☐ Positively reinforce follow-up visit.	

CHECKLIST 13: EXPLAINING TREATMENT FOR VAGINAL DISCHARGE

	Resources
☐ Topic	
☐ Explain the diagnosis.	See COGS for more information.
☐ Explain the cause of the infection.	
☐ Help the client take the medicine.	
☐ Explain the importance of taking all medicines correctly and completely.	
☐ Explain the long term effects of not curing the infection.	
☐ Explain alcohol interaction and emphasize need not to drink while taking the medicine.	
☐ Check on pregnancy prevention method.	
☐ Help client plan to take all the medicine.	
☐ Explain what to do if client forgets a dose of medicine.	
☐ Reinforce the plan.	
☐ Teach about side effects and reasons to contact a doctor.	
☐ Introduce partner notification/treatment. Refer to sexual history.	
☐ Explain need to use condoms or abstain from sex until all the medicine has been taken.	
☐ Introduce risk reduction planning.	
☐ Plan for risk reduction or review previous plan.	
☐ Suggest an HIV test.	
☐ Make appointment for your client to return.	
☐ Once again, positively reinforce follow-up visit.	

CHECKLIST 14: EXPLAINING TREATMENT FOR URETHRAL DISCHARGE

	Resources
☐ Explain the diagnosis.	See COGS for more information.
☐ Explain how the client got the infection.	
☐ Explain the medicine.	
☐ Acknowledge the number of pills, and help client take them.	
☐ Explain/show the medicines and how they are to be taken.	
☐ Help client plan so client can remember to take all the medicine as prescribed.	
☐ Explain what to do if the client forgets a dose of medicine.	
☐ Reinforce the plan.	
☐ Reinforce the need to take all the medicine, on time.	
☐ Teach about side effects or reasons to contact a doctor.	
☐ Advise client how to know if he or she should come back.	
☐ Reinforce client's decision to come for examination and treatment.	
☐ Introduce partner treatment. Refer to history re. regular partners.	Annex 2.8, Checklist 19: Helping HRG Clients with Partner Notification and Treatment
☐ Introduce and carry out, or update, risk reduction planning.	Annex 2.6, Checklist 10: Counseling for Risk Reduction Planning
☐ Offer condoms and check on ability to use correctly.	Annex 2.6, Checklist 11: Helping HRG Clients Use Male Condoms Correctly
☐ Suggest and discuss an HIV test.	Annex 2.10, Checklist 20: Recommending an HIV Test to Your HRG Client
☐ Make appointment for client to return.	
☐ Reinforce client's decision to return for follow-up and explain link between HIV and STI.	

CHECKLIST 15: EXPLAINING TREATMENT FOR SCROTAL SWELLING

Note: If this is a case of treatment failure — that is, if the client has already been treated for this infection. See Section 2.12: Counseling for Treatment Failure or Re-infection.

	Resources
Explain diagnosis.	See COGS for more information.
Explain cause of STI.	
Explain importance of treatment.	
Help client plan to take all the medicine.	
Explain what to do if client forgets a dose of medicine.	
Reinforce the plan.	
Reinforce the need to take medicine completely.	
Teach about side effects and reasons to contact a doctor.	
Teach other care; ask if there is anything/any position that makes the swelling feel less painful.	
Introduce partner notification/treatment. Refer to sexual history.	Annex 2.8, Checklist 19: Helping HRG Clients with Partner Notification and Treatment
Plan for risk reduction or review previous plan.	Annex 2.6, Checklist 10: Counseling for Risk Reduction Planning
Offer condoms and check on ability to use correctly.	Annex 2.6, Checklist 11: Helping HRG Clients Use Male Condoms Correctly
Suggest an HIV test.	Annex 2.10, Checklist 20: Recommending an HIV Test to Your HRG Client
Make appointment for client to return.	
Reinforce client's decision to come for follow-up and explain link between HIV and STI.	

CHECKLIST 16: EXPLAINING TREATMENT FOR PROCTITIS (INFLAMMATION OF THE RECTAL WALL)

Note: If this is a case of treatment failure — that is, if the client has already been treated for this infection, see Section 2.12: Counseling for Treatment Failure or Re-infection.

	Resources
Explain diagnosis.	See COGS for more information.
Explain cause of proctitis.	
Explain importance of treatment.	
Explain treatment.	
Acknowledge the number of pills and help the client take them (Cefiximine 400 mg single dose and Azithromycin 1 g oral single dose).	
Reinforce client's decision to come for treatment.	
Teach about side effects and reasons to contact a doctor.	
Teach other care.	
Introduce partner notification/treatment. Check history for regular partner or ask.	Annex 2.8, Checklist 19: Helping HRG Clients with Partner Notification and Treatment
Plan for partner treatment.	
Introduce or update risk reduction planning.	Annex 2.6, Checklist 10: Counseling for Risk Reduction Planning
Offer condoms and check on ability to use correctly.	Annex 2.6, Checklist 11: Helping HRG Clients Use Male Condoms Correctly
Suggest HIV test.	Annex 2.10, Checklist 20: Recommending an HIV Test to Your HRG Client
Make appointment for client to return for next visit.	
Reinforce again the client's decision to return for follow-up.	

CHECKLIST 17: COUNSELING FOR TREATMENT OF INFECTION IN THE THROAT

HRG clients who have had unprotected oral sex and who have a very sore throat may have an STI infection in their throat.

	Resources
☐ Explain diagnosis.	See COGS for more information.
☐ Explain cause of this STI.	
☐ Explain importance of treatment.	
☐ Explain treatment to be given.	
☐ Teach about side effects and reasons to contact a doctor.	
☐ Advise client how to know if he or she should come back.	
☐ Introduce partner treatment. Refer to history re. regular partners.	Annex 2.8, Checklist 19: Helping HRG Clients with Partner Notification and Treatment
☐ Introduce and carry out, or update, risk reduction planning.	Annex 2.6, Checklist 10: Counseling for Risk Reduction Planning
☐ Offer condoms and lube, and make sure client can use them correctly.	Annex 2.6, Checklist 11: Helping HRG Clients Use Male Condoms Correctly
☐ Suggest an HIV test.	Annex 2.10, Checklist 20: Recommending an HIV Test to Your HRG Client
☐ Make appointment for client to return.	
☐ Reinforce client's decision to come for follow-up and explain link between HIV and STI.	

CHECKLIST 18: COUNSELING FOR TREATMENT FAILURE OR RE-INFECTION

	Resources
☐ Go over the problem the client is having today and check on reason for last visit.	HRG client record
☐ Introduce possibility that this is the same infection client had at last visit.	HRG client record
☐ Remind client of previous visit and treatment.	
☐ Assess possibility the client did not take all of his or her medicine if there was medicine to take outside of the clinic visit.	
☐ If the client didn't take the medicine completely, assess reasons.	
☐ If all medicine was taken correctly, assess possibility of re-infection.	
☐ Help client review and update risk reduction plan.	
☐ Offer condoms and lube, and make sure client can use these correctly.	Annex 2.6, Checklist 11: Helping HRG Clients Use Male Condoms Correctly Condoms, lubricant
☐ Motivate client for partner notification and treatment, and help plan for partner treatment.	Annex 2.8, Checklist 19: Helping HRG Clients with Partner Notification and Treatment
☐ Document discussion and plan.	

2.8 Counseling for Partner Notification

CHECKLIST 19: HELPING HRG CLIENTS WITH PARTNER NOTIFICATION AND TREATMENT

	Resources
☐ Check on regular partner relationships. Refer to sexual history and ask client.	
☐ Assess condom use in regular partner relationship/s.	
☐ Explain importance of having regular partners treated for the STI also.	
☐ Assess barriers to informing and encouraging HRG client's partner re. need for STI treatment.	
☐ Assess for potential violence.	
☐ Discuss options for partner treatment and select an option.	
☐ Rehearse telling the partner or make plan for other options.	
☐ Review risk reduction plan and updates.	
☐ Reinforce any positive steps already taken.	
☐ Offer condoms and lube, and check on ability to use correctly.	Annex 2.6, Checklist 11: Helping HRG Clients Use Male Condoms Correctly Condoms, lubricant
☐ Continue with session.	

2.9 Counseling IDU

BACKGROUND INFORMATION FOR COUNSELORS ON INJECTING DRUG USE

How People Use Drugs

Clients who use drugs may be smoking, ingesting (swallowing), or injecting. While many people smoke cannabis/ganja or opium/heroin, injecting is the most likely to contribute to HIV infection because users often share drug injecting equipment and drug solutions. Injecting drug use may also be more easily hidden, at least at first.

People also switch to injecting when the cost of drugs goes up. Injecting gives a greater effect, there is less chance of wasting the drug, and it is easier to divide the drugs among several people who have put their money together to buy.

Injecting-drug Dependence or Addiction

Opioid drugs are depressants. They slow down central nervous system messages going to and from the brain: physical, mental, and emotional. Dependence can be physical, psychological, or both. Some people use drugs only from time to time. Counselors will need to assess the impact that drug use is having on the HRG client's life.

Dependence occurs because continuous use of the drug changes brain chemistry — the brain does not work the same way it did before. When the drug is taken away, the brain causes withdrawal symptoms: nausea, muscle spasms, cramps, anxiety, fever, and diarrhea. People who are drug dependent need the drug to avoid feeling these symptoms. They may need increasing amounts just to prevent the negative feelings of withdrawal, let alone to feel intoxication.

When people are addicted to or dependent on a drug, their lives center on getting and using the drug, regardless of the economic and social costs.

Physical Effects of Heroin

IMMEDIATE EFFECTS:

- intense pleasure, feeling of well-being
- warm flushing of skin
- dry mouth, heaviness of extremities
- nausea, vomiting, severe itching
- drowsiness

AT HIGHER DOSES:

- poor concentration
- falling asleep
- slow or shallow breathing
- nausea and vomiting
- sweating, itching, increased urination

Common Health Problems Related to Use of Heroin or Other Opioids

LONG-TERM EFFECTS:

- heart and bronchial problems
- loss of appetite, possible nutritional deficiencies
- dental problems due to craving for sweet food/drinks
- pneumonia

- chronic constipation
- reproductive and sexual health problems

OVERDOSE

Coma and death may occur as a result of excessive slowing of the central nervous system. The drug user may stop breathing.

Overdose is more common among new users and people who have stopped using for a period and started using again. These users will have lost the accumulated tolerance to higher amounts of the drug. If they start again with the same amounts as before, they may overdose.

WITHDRAWAL

Withdrawal may occur within a few hours after the last time the drug is taken. About eight to 12 hours after the last heroin use, an addict's eyes begin to water and he or she starts to experience flu-like symptoms: sneezing, weakness, depression, muscle cramps, nausea, vomiting, and diarrhea. The symptoms increase in severity over two to three days. Within a week to 10 days the illness is over. Drug withdrawal feels very bad, but it does not damage any body organs.

CRAVING

Intense feelings of desire or need for drugs, craving can be triggered by "cues," even many years after quitting drug use. Cues may be sights, sounds, smells, or even thoughts associated with drug taking. They may cause release of the same brain chemical that causes a drug high. Research has shown that intense cravings can be triggered in the brain, just by thinking about drugs or being reminded in some way. This is one reason that stopping drug dependency is very difficult.

Common Health Problems Relating to Injection

BLOODBORNE DISEASES

- HIV
- Hepatitis B and C
- Syphilis

OTHER INFECTIONS

- Endocarditis: inflammation of the heart; can lead to scarring of heart blood vessels and valves
- Sepsis: bacteria in the blood; fever > 38.5 degrees Celsius

LOCALIZED INFECTIONS: ABSCESS

Unclean injection sites, contaminated drugs, intramuscular and subcutaneous injection, missing a vein, and using dull needles can lead to formation of an abscess: a localized infection.

PREVENTING ABSCESSES

Washing the injection site with soap and water or alcohol will decrease the germs that can be introduced into the body during the injection. Injecting subcutaneously or intramuscularly can create local inflammation that can develop into an abscess. Injecting is less likely to result in an abscess if using a new needle for each injection or not reusing the needle if the injection is "missed" — that is, if the vein is missed on the first try.

Clinics serving IDU populations should be prepared to treat abscesses.

SCARRING AND COLLAPSED VEINS

Over time, frequently used veins can become scarred or collapse, making them unavailable for injection. Clots can form that can break loose and cause blockage. If a clot gets into the heart, brain, or lungs, this can result in death. Rotating

injection sites, using sharp needles, and using as small a needle as possible can help prevent clots. Sharpening needles on stones or matchboxes can cause barbs to form, and these are hard on veins and tissues.

INJECTION SITES

Another danger associated with collapsed or scarred veins is that IDU will need to use sites that are less safe for injection.

- Arms are the lowest risk; upper is better than lower.
- Hands are relatively low risk, but the veins are small.
- Legs are medium risk. Circulation is less strong than in veins closer to the heart. Blood clots are more likely to form.
- Feet are also medium risk. Veins will take longer to heal as the circulation is slower. Sites are harder to keep clean.
- Groin is high risk. The big vein: the femoral vein is close to the femoral nerve and artery.
- Neck is high risk. Injecting into the carotid artery can cause death.
- Under the tongue.

IDU should always check for a pulse before injecting. If one can be felt, this is an artery. It is very dangerous to inject into an artery.

Heroin's Effects on Reproductive and Sexual Health

Men: Long-term use can result in decrease in sex drive, impotence (inability to get/maintain an erection, achieve orgasm).

Women: Long-term use can result in reduced hormone production, which results in disruption (or stopping) of menstrual periods and possible infertility. Women may also have reduced sex drive and inability to reach orgasm.

OTHER VULNERABILITY

Women drug users are more highly stigmatized than are male IDU, and less likely to use available harm reduction and drug rehabilitation services, which may not be set up to attract or provide services to women. Women who have children will find it difficult to make use of residential treatment programs, or to regularly attend programs offering care during the day.

WOMEN, HEROIN, AND PREGNANCY

- Heroin is short acting, and maintenance requires frequent use. Without this, users may experience withdrawal symptoms, including cramping.
- Heroin use can result in premature delivery or loss of pregnancy.
- Babies born to drug-addicted mothers are often underdeveloped, small, and have breathing problems or infections shortly after birth.
- These babies are also likely to be drug dependent and will need medical care to go through drug withdrawal after birth.

PREVENTING BLOODBORNE INFECTIONS: RISK REDUCTION INFORMATION FOR IDU

HIV and Hepatitis C and B can be transmitted or "caught" when tiny amounts of infected blood get into an IDU's blood. The infected blood may have been on or in the injecting equipment or in drug solutions or other drug preparation equipment.

There are multiple opportunities for infection in the process of preparing and using drugs. Counselors should ask their clients how they go about buying and using drugs, step by step.

Risks of HIV can come from the needle/syringes, the cookers, water and mixed drug solutions, and filters. Counselors should help clients identify the points when infection could happen and what they can do to decrease the risk of infection. Counselors should teach needle cleaning through demonstration and have clients demonstrate back, just as counselors teach condom use.

Counseling and health education points will include:

1. Don't share or reuse injection equipment.

The most certain method of prevention due to sharing or reusing injection equipment is to always use one's own needle/syringe. The same applies to cookers, cottons, and spoons.

If possible, IDU should always keep their own needle/syringe until they have a new one in hand. This may mean hiding it where it can't be picked up and used by anyone else. Needles and syringes that will be reused should be flushed with cold water after use, before blood or other matter has a chance to dry.

2. Clean injection equipment if you have to reuse.

Ideally, injection equipment should be cleaned using bleach and water.

Instructions for Cleaning

PART ONE

- Pour clean water into a cup, cap, or something that only you will use.
- Fill the syringe by drawing the water up through the needle to the top of the syringe.
- Shake it around and tap it to loosen the blood.
- Squirt out the water and repeat at least three times (do not reuse water).

PART TWO

- Pour some undiluted bleach into a cup, cap, or something that only you will use.
- Fill the syringe by drawing the bleach up through the needle to the top of the syringe.
- Shake it around and tap it. Leave the bleach in the syringe for at least 30 seconds.
- Squirt out the bleach and repeat at least three times (do not reuse bleach).

PART THREE

- Pour new clean water into a cup, cap, or something that only you will use. Don't use the water from part one.
- Fill the syringe with water to rinse out the bleach. Fill the syringe by drawing the water up through the needle to the top of the syringe.
- Shake it around and tap it for at least 30 seconds.

- Squirt out the water and repeat three times (do not reuse water).

PART FOUR: OTHER CLEANING TIPS

- If it's possible to take the syringe apart and soak it in bleach for 30 seconds, this is best. Make sure all the bleach is rinsed off before using the syringe.
- Clean needles and syringes that are bought outside of a pharmacy before they are used because sometimes dirty equipment is repackaged and sold as new.
- Equipment that is sterile should not be "cleaned" as this could actually contaminate it.
- Store all bleach for cleaning needles and works in a container that does not let light pass through; bleach loses its effectiveness if exposed to light over time.[9]

Cookers: Be sure to soak the cooker in bleach for 30 seconds if it's going to be shared. Split whatever you are using as a filter in two before you use it. It isn't possible to clean the filter.

Note: A cooker can be any utensil used to heat and dissolve a powdered drug in water so it can be injected.

Water for drug solution and cleaning: Make sure the water you use is as clean as possible. This is especially important for people with HIV, AIDS, or other serious health conditions. Do not share water/draw up from the same water. Water should be from a moving source (i.e., not stagnant water).

Alternatives to bleach: If the HRG client does not have bleach, he or she can use hydrogen peroxide, a solution of dishwashing liquid and water, or rubbing alcohol. Using high-proof drinking alcohol such as vodka or rum is somewhat helpful, if that is all that's available. This is not as effective as bleach, but more effective than not cleaning.

Counselors should encourage clients to do whatever they can to clean. Any cleaning is better than none. Tell them to use water that is as clean as possible for any rinsing or mixing.

Filters: Cigarette filters are not safe to use since they contain tiny pieces of glass, and, if the filter is from a cigarette that has already been smoked, it also contains substances from the smoke that can be harmful if injected.

Counselors should advise clients to use fresh cotton every time they shoot up, and as with needles, syringes, and cookers, to never share cotton with someone else: infections, bacteria, and viruses can all be transmitted through sharing cottons.

Clients should not try to salvage the drug from old filters by cooking or squeezing them. Germs can easily live and grow in old filters and cause an infection/fever.

Preventing Hepatitis B and C

In order for bleach to kill hepatitis B, C, and HIV, the syringe and/or cooker must be in the bleach for 10 minutes.

9 http://www.thewellproject.org/en_US/Living_Well/Health/Cleaning_Works.jsp

Dividing drugs: The safest way to divide drugs is to split the drug and have each person prepare it using their own equipment and materials. If this option is not possible or acceptable, the drugs can be cooked up first (using sterile equipment) and then divided (using sterile syringes) after they're in liquid form. Clients should always use sterile equipment or well-cleaned equipment if sterile is not available.

DIVIDING CAN BE DONE IN TWO WAYS:

Backloading (piggybacking): A single, sterile syringe can be used to draw up equal amounts of the liquid, which can then be carefully squirted into the back of each person's sterile syringe after the plunger has been removed.

Frontloading: The drug can be carefully squirted into the front of each person's syringe that still has the plunger in it but from which the detachable needle has been removed.

2.10 Counseling to Promote HIV Testing

CHECKLIST 20: RECOMMENDING AN HIV TEST TO YOUR HRG CLIENT

	Resources
☐ Introduce the idea of having an HIV test when it fits into the discussion with the client.	
☐ Check on previous experience with HIV testing.	
☐ If the client has had an HIV test and reports a **negative result,** assess window period, and offer help to client to stay negative or to retest, depending on date of test.	
☐ If the client has had an HIV test and reports a **positive result,** offer to talk with the client about sexual health/ issues.	
☐ If client has not had an HIV test and is willing to talk or is uncertain, offer to tell the client more about what happens during an HIV test and help the client explore the possible benefits or disadvantages.	Section 2.14, Table 4: Advantages and Disadvantages of Having an HIV Test
☐ If the client doesn't want to talk about an HIV test now, accept the decision. Leave an opening to come back and talk again about this later. ☐ Offer a copy of the VCT handout if you have one.	VCT handout
☐ If client thinks he or she might want to have an HIV test, make an appointment or referral for pretest counseling.	Referral directory and referral form
☐ Confirm a time and acknowledge that the client might feel a bit anxious. Reinforce decision again.	

2.11 Overview of HIV Pre- and Post-Test Counseling

The following is an overview. It is not a substitute for training in pre- and post- HIV test counseling or any other counseling of HIV-positive clients. Any Avahan counselors who are expected to do HIV pre- and post-test counseling or counseling of HIV-positive HRG clients must be given appropriate training and additional supervision. This counseling should be based on the NACO VCT guidelines and training curriculum. As these materials are aimed at the general population, counselors will need additional training for counseling HRG clients, particularly those who test HIV-positive. New guidelines and training materials will be needed for counseling HRG populations on positive prevention, as these are not yet available in India.

Counseling HIV-positive male and female HRG clients for positive prevention will be especially challenging. Again, counselors and supervisors will require additional specialized training if ethical, competent services are to be given to HIV-positive clients.

CHECKLIST 21: PRE-TEST COUNSELING – USING A RAPID HIV TEST

Greet the HRG client, confirm that the client has come to consider an HIV test, and introduce the client to the process of HIV counseling and testing.

- ☐ Inform client about the amount of time for counseling.
- ☐ Stress and explain confidentiality.
- ☐ Obtain client information.
- ☐ Assess client's knowledge of HIV and AIDS and concerns.
- ☐ Find out what has prompted the client to come for testing.
- ☐ Find out about any previous HIV tests the client has had.
- ☐ Explore the HRG client's understanding of an HIV test.

Explore the HRG client's understanding of an HIV test.

- ☐ Explain what positive test result means.
- ☐ Explain what negative test result means.
- ☐ Explain window period.
- ☐ Explore personal implications of test results.
- ☐ Assess client's support system in case of positive results.
- ☐ Encourage questions, check understanding.
- ☐ Create a risk reduction plan.

Create a risk reduction plan.

- ☐ Take sexual history (or review sexual history of STI HRG clients).
- ☐ Determine risky behaviors based on sexual history.
- ☐ Help client assess costs and benefits of behaviors and risk reduction.
- ☐ Explore successes and reinforce any steps taken.
- ☐ Identify barriers and discuss how they can be overcome.
- ☐ Create a risk reduction plan with the client.
- ☐ Obtain informed consent and prepare for next steps.

Obtain informed consent and prepare for next steps.

- ☐ Explain how the HIV test is done.
- ☐ Explain and obtain informed consent.
- ☐ Make appointment for post-test counseling.
- ☐ Reinforce client's decision to have test.
- ☐ Show client where to go/wait to have blood taken.

POST-TEST COUNSELING

Post-test counseling is done when the HRG client receives his or her test results. The counseling will depend on whether the test results are positive or negative.

CHECKLIST 22: POST-TEST COUNSELING: NEGATIVE TEST RESULT

- ☐ Greet client and ask if client is ready to hear results.
- ☐ Give test results clearly and simply.

Counsel on window period and retesting.

- ☐ Provide information on window period and negative test results.
- ☐ Assess need for retesting.
- ☐ Check on any risk during the waiting period.
- ☐ Schedule retesting if needed.

Create or alter risk reduction plan.

- ☐ Create or update risk reduction plan for window period/retest.
- ☐ Identify any positive events or accomplishments, even if these are less than what was planned. Positively reinforce these achievements.
- ☐ Review pre-test risk reduction plan.
- ☐ If you've identified remaining risks, help the client create a risk reduction plan for these.
- ☐ Assess and revise plan as needed.
- ☐ Discuss family planning needs. Promote condoms as dual protection: unwanted pregnancy and STI, including HIV.

Close counseling session.

- ☐ Summarize plans for risk reduction.
- ☐ Ask if there are any last questions or concerns.
- ☐ Close session.
- ☐ Offer sources of more information.
- ☐ Give leaflets if you have any that are appropriate.

CHECKLIST 23: POST-TEST COUNSELING: POSITIVE TEST RESULT

- ☐ Greet the client and assess the client's readiness for hearing that he or she has a positive HIV test (has HIV infection).
- ☐ Give test results clearly and simply.

Ask what the client understands about that result.

- ☐ Allow time for the test result to sink in. Let the client respond to the result.
- ☐ Ask if the client has questions and make sure the client has understood the test result.
- ☐ Assess the client's emotional state.
- ☐ Deal with immediate emotional reactions.
- ☐ Discuss how the client will spend the next few hours and days. Help the client avoid destructive behavior.
- ☐ Discuss potential ways of getting support; help client plan for this.
- ☐ If appropriate, discuss the difference between HIV and AIDS.

Counsel HRG client to support positive living.

- ☐ Assess client's needs: psychosocial and medical.
- ☐ Provide information and referrals regarding healthy living, support, and nutrition.
- ☐ Provide information and referrals regarding medical care.

Create or alter risk reduction plan.

- ☐ Review pre-test risk reduction plan.
- ☐ Explain options of positive prevention.
- ☐ Assess risk reduction plan and update as needed.
- ☐ Plan for partner notification.
- ☐ Plan for disclosure to other trusted person/s.
- ☐ Discuss family planning needs in addition to condom use.
- ☐ Summarize plans for positive living and risk reduction.
- ☐ Provide or reinforce referrals.
- ☐ Make plans to provide additional counseling if needed.
- ☐ Close session.

COUNSELING HIV-POSITIVE HRG CLIENTS

Emotional/Psychosocial Support

Psychosocial support is fundamental to counseling. Very often a positive HIV diagnosis brings a lot of anxiety and confusion to the HRG client. The client may also become extremely depressed and may think about suicide. The client is likely to feel very worried and frightened about the future, and will have fears about facing partner/s and family members. There is also fear of discrimination from the community, if the client's status becomes known. In addition, HRG clients are faced with the need to continue working and earning, regardless of their HIV-positive status. Most clients will not have other ways of earning money. Their ability to negotiate condom use to protect themselves and their partners is extremely important. HRG clients will need to understand the additional risks to their health through unprotected sex and feel motivated to protect themselves and their partners.

THE FOLLOWING FACTORS ARE IMPORTANT:

- current health status of the HRG client
- availability of appropriate, non-stigmatizing healthcare
- preparedness of the HRG client to receive the test results
- need to keep the diagnosis secret, and to continue working
- amount of support from family and community
- personality and mental health status
- cultural and spiritual values
- availability of support counseling

HRG CLIENTS WHO ARE HIV-POSITIVE MAY EXPERIENCE:

- **a sense of loss:** about dreams for the future, who they are as a man, as a woman, as a mother or father, as a husband or wife, or as a partner, lover, or beloved
- **a sense of limitation:** Will it be possible to have an intimate partner? A satisfying sex life? Children? Will it be possible to live to raise children?
- **a sense of self blame** for not avoiding HIV infection
- **anger about having become infected**, which may be directed at a specific partner or at partners in general. A few clients may have thoughts of getting revenge by allowing others to become infected.
- **depression and a sense of helplessness**
- **fear** of telling a partner, of illness, of stigma should others learn
- discrimination and stigmatization by clinical care providers

COUNSELORS SHOULD:

- Help the HRG client deal with spoken and unspoken feelings.
- Assist the client in overcoming the difficulties of adjusting to her/his situation.
- Provide referrals for practical needs.

HIV-positive Sex Workers

Giving practical support to HIV-positive sex workers who do not have other financial options and who will not be able to stop selling sex will be challenging for counselors. Counselors will need to carefully assess their own feelings, attitudes, and beliefs about HIV-positive people having sexual desires and needs, in addition to

the prospect that their clients will most likely continue to have sex with multiple partners.

Most information about counseling HIV-positive people is written for the general population of men, women, and children. For HRG clients who are economically dependent on sex, the burden of prevention becomes even greater. HRG clients will need to take responsibility for protecting their own health and will also be responsible for protecting the health of their partners or clients, often without telling their clients out of fear of losing them.

Counselors will need to help HRG clients develop a strong sense of concern about their own health and future, matched by confidence and skills to take steps to protect themselves as well as a strong sense of responsibility for others.

➔ There is no specific law in India that places a legal burden on an HIV-positive client for disclosure or prevention of infection of a partner. However, there is a legal precedent for use of existing laws to prosecute persons who know they are HIV-positive and who have transmitted the infection to a partner.

COUNSELING HIV-POSITIVE CLIENTS ON POSITIVE PREVENTION

(Refer back to the section on sexuality, sexual health, and sexual rights.)

People with HIV are normal people, with normal sexual and reproductive feelings, concerns, and needs. These concerns and needs will change over the course of their lives. Their sexual and reproductive feelings, concerns, and needs are also affected by having a serious infection that can be passed on through unprotected sex. Unprotected sex also has risks for the person who is positive.

Men and women who are HIV-positive need to have their sexuality accepted and supported by counselors. Counselors can play an important role in the ability of HIV-positive men and women to have a satisfying and safe personal sex and reproductive life and to protect themselves and others where sex is a factor of economic need.

If clients feel they can't talk openly about sexual feelings and needs or about reproductive desires, it will be very difficult for them to make plans to protect themselves and others. Many people with HIV feel they don't have a right to talk about sexual or reproductive needs. Counselors should raise the topics of sex and sexuality for HIV-positive clients and invite them to talk. If the counselor can show acceptance of their clients' sexual feelings and concerns, or concerns about reproduction, it will be easier for clients to raise issues they may be afraid to discuss.

Specific issues for counseling clients about sex and sexuality may include:

- fear of infecting someone else
- fear of others finding out, losing community and livelihood
- fear of being unable to find an intimate partner who will accept them if they are HIV-positive
- fear of losing an intimate partner when the partner learns of their HIV status
- desire to protect self and client vs. potential of losing a client

- physical problems: lack of energy, infections
- women with HIV being more likely than men to have problems of the reproductive/sexual organs: cervical dysplasia, vaginal candidiasis, menstrual irregularities
- medication side effects that affect sexual function
- desire for pregnancy or avoiding unwanted pregnancy
- overemphasis by caregivers and counselors on physical health and medical issues
- restriction by care providers of discussion about sex and sexuality, prevention, and condom use
- personal attitudes and values of care providers regarding sexuality of people living with HIV/AIDS
- "prevention fatigue": a decrease in the amount of energy a client is willing to spend on continuous efforts to prevent sexual transmission, especially with regular partners

Family Planning

HRG clients on ART need to know that some ARV drugs may reduce the effectiveness of some hormonal contraceptives. They should ask their doctor, as not all ARVs will do this.

If possible, women on ART or men whose partners are on ARVs should be referred to an ART center for assistance with contraceptive choices. The HRG client may choose to use condoms for STI/HIV prevention and another method for pregnancy prevention, or use male/female condoms correctly and consistently to help protect against both pregnancy and STI/HIV.

Counseling for Positive Living

People living with HIV/AIDS should be provided counseling on positive living: that is, living life as fully as possible, while slowing progression of the disease. Positive living includes making positive choices to care for one's mental and physical health, having a positive outlook on life, learning how to avoid giving HIV to someone else, and protecting oneself. The following key points should be emphasized with HIV-positive HRG clients. This should be done over time, according to the client's needs and ability to take in new information.

- Be informed.
  - Encourage HIV-positive HRG clients to learn what they can about HIV infection.
- Take medications as prescribed.
  - There is no cure for HIV infection, but medications can help clients live healthier and longer lives (opportunistic infection [OI] prevention, OI medications, and ART).
  - Some medications can interact with ART. Clients should not take any medications without consulting a doctor.
  - Avoid alcohol, cigarettes, and illegal drugs.
  - TG HRG clients should consult with a doctor if they are taking hormones and need ART.
- Work and get exercise as your energy allows.
- Avoid exposure to infection and transmission of infection: positive prevention.

  - Family planning: consider using a backup method to prevent pregnancy.
  - STI/HIV prevention: use condoms.
  - Pregnancy: make use of PPTCT services.
  - Make prompt use of clinical services for any symptoms of illness.
- Avoid stress.
- Maintain good nutrition:
  - Devise a healthy eating plan: a high calorie, high protein, low fat, vitamin- and mineral-rich diet.
  - Avoid spicy food: chilies, pepper, too much masala.
  - Avoid oily food: butter, ghee, fried foods, and excess oil while cooking.
  - Include pulses and sprouted, steamed legumes in daily diet.
  - Include at least one vegetable and one seasonal fruit daily.
  - Include one egg and two glasses of milk daily.
  - Fish is the best flesh food. Mutton and chicken can also be included.
  - Eat small frequent meals when unable to eat whole meals.
- Keep up daily personal hygiene.
- Exercise and rest:
  - Exercise regularly.
  - Get enough rest.
  - Get enough sleep (at least eight hours).
  - Do meditation/yoga.
- Prevent infections:
  - Drink clean water (boiled water).
  - Avoid food that may contain unboiled water, like chutney, iced drinks, and buttermilk.
  - Wash vegetables and fruits with clean water.
  - Eat well-cooked food.
  - Wash hands with soap frequently.
  - Avoid STI and HIV re-infection by using condoms and having non-penetrative sex.
  - Take steps to avoid malaria (use bed nets).
  - Avoid contact with others who are sick.
  - Clean and cover wounds.
- Monitor general health.
- Find people to talk to for emotional support.
- Find support groups and positive networks of people living with HIV/AIDS (PLHA).
- Seek spiritual and other counseling.
- Make plans for the future, such as preparing wills and inheritance deeds.
- Think positively.

Annex 3

3.1 Sexual Health and Rights

SEXUAL HEALTH DEFINITION

Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled.[10]

Counselors play an essential role in helping their HRG clients understand and achieve sexual health. Sexual rights and sexual health definitions apply to all HRG clients, regardless of sexual or gender identity and HIV status.

SEXUAL RIGHTS DEFINITION

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents, and other consensus statements. They include the right of all persons, free of coercion, discrimination, and violence to

- achieve the highest attainable standard of sexual health, including access to sexual and reproductive healthcare services
- seek, receive, and impart information related to sexuality
- receive sexuality education
- have respect for bodily integrity
- choose their partner
- decide to be sexually active or not
- have consensual sexual relations
- have consensual marriage
- decide whether and when to have children
- pursue a satisfying, safe, and pleasurable sexual life

10 http://www.who.int/reproductive-health/gender/sexualhealth.html

Annex 4

4.1 Supervision and Support for Counselors

Supervisors who have counseling expertise should assess a counselor's interactions with HRG clients. This will require explaining to HRG clients the reason for the assessment, what will be done, and how the information will be used. It also will involve reassuring clients about confidentiality, getting their permission, and introducing the supervisor to the client before the counseling session.

COUNSELING ASSESSMENT METHODS

Direct Observation

The supervisor must ask permission from the HRG client before observing the session; it is also important to know the counselor's and client's comfort level prior to the observation. At the end of the observation, the supervisor can ask the counselor to fill in a copy of the Self Assessment form on page 132. Then the supervisor will discuss his or her observations with the counselor, along with assessing how the counselor felt about the session.

THE SUPERVISOR COULD ASK THE COUNSELOR THE FOLLOWING:

1. Can you give examples from the session of what you feel you handled well?
2. Can you talk about some of the issues you feel you could have handled differently?
3. What and how could you have changed to make this session better?

Role Play/Mock Session

If it is not possible to observe a session, the supervisor may choose to use a role-play session to assess how the counselor might handle an issue or counseling session. Here the supervisor takes on the role of an HRG client. The purpose of the counseling session is defined before starting. Although less realistic, the role-play allows the supervisor to raise specific issues or challenges. This technique helps the supervisor analyze how the counselor is handling certain issues; the counselor's comfort level in exploring sexual behavior and various sexual activities; the counselor's attitudes and beliefs; and how these attitudes and beliefs could interfere with the counseling sessions. The supervisor will need to be very well informed about the HRG client if the role play is to be effective.

TOOL: COUNSELOR SELF ASSESSMENT

SELF ASSESSMENT FORM

Date:	Client Code:
Clinic Name and Address:	Counselor Name:

	Yes	No	N/A
Conducted a client-centered counseling session that responded to the HRG client's needs and concerns.	☐	☐	☐
Used appropriate communication skills.	☐	☐	☐
Provided appropriate technical information.	☐	☐	☐
Encouraged HRG client to speak as much or more than I did.	☐	☐	☐
Performed a risk assessment.	☐	☐	☐
Worked with the client to develop a risk-reduction plan.	☐	☐	☐
Client understood and agreed to follow risk reduction plan.	☐	☐	☐
Assessed and addressed the availability of the client's social support.	☐	☐	☐
Discussed relevant referral options with the client.	☐	☐	☐
Discussed partner notification and partner treatment with the client.	☐	☐	☐
Discussed routine medical checkup and asymptomatic treatment with the client.	☐	☐	☐
Dealt with the client's and my own emotional reactions.	☐	☐	☐

What did I do well? _____

_____

What could I improve on? _____

_____

Professional issues for follow-up: _____

_____

Annex 5

5.1 Preventing and Managing Counselor Burnout

SITUATIONS IN AVAHAN CLINICS THAT MAY CONTRIBUTE TO BURNOUT, AND OPTIONS FOR PREVENTION

Client Overload

Many clients come during hours when doctors are present. Long waiting times may discourage clients from using the services. Counselors may not have time to prepare for sessions, counsel adequately, and document counseling sessions between clients.

POSSIBLE SOLUTIONS:

- If this is a regular situation, the clinic needs to recruit another counselor, even if only for peak times.
- Pull client records pulled from files and have them ready for the counselor before he or she sees the client.
- Allocate time for completing the client record. If this is left until later, important information may be forgotten.
- Make sure client flow is as smooth as possible and that all clients know how long the wait might be and how many clients are ahead of them. Paying attention to clients while they are waiting can decrease their frustration.
- As much as possible, prepare PEs/HRGF or community counselors to take responsibility for health education sessions while clients are waiting to see the doctor or counselor.

Handling Emotional Issues Over a Period of Time

Hearing about problems that sometimes seem to have no good solution, or dealing with clients who have many emotional problems, may lead the counselor to become emotionally exhausted and insensitive.

POSSIBLE SOLUTIONS:

- Case reviews with peers and supervisors can be very helpful and are a requirement in professional counseling services.
- An organization that pays attention to staff emotional needs is less likely to lose staff to burnout. Management can give time and encouragement for simple staff activities such as eating together, celebrating important events in staff member's lives, and celebrating holidays.
- The agency can also send counselors to appropriate workshops/meetings that provide a change and an opportunity to share issues and solutions. A short change of environment will help the counselor.
- Supervisors can help counselors to recognize the contributions they are making.

Lack of Supervision and Support Specific to Counseling Responsibilities and Demands

Avahan clinics are expected to provide quality services. Any counselor will have clients or cases they feel uncertain about. Many STI counselors do not have extensive training or counseling experience, particularly with the populations they are working with. Counselors may become frustrated because they have unrealistic personal expectations for clients that the clients don't meet; some HRG clients will come back over and over with the same issues; others will not seem to be making any behavioral changes in spite of repeated sessions. This is particularly difficult as these expectations may be linked to the program objectives/expectations.

If counselors do not have anyone to share their concerns and doubts with, they may feel very insecure and helpless. Over time, this can contribute to burnout.

POSSIBLE SOLUTIONS:

- The counselor should have the opportunity to meet with a qualified counseling supervisor no less than once a month on a regular schedule. A trained and experienced counselor should conduct a counseling supervision session. The session may include review of cases (including case records) and at least one observed session with constructive feedback. This can only be done by a qualified counselor, ideally one who has insights into the client population.
- Supportive supervisors can help counselors recognize and manage unrealistic expectations of themselves and of clients. This is especially important given the pressure of meeting project objectives and the limited professional training of many counselors. Supervisors who have counseling backgrounds are likely to be more effective with this.
- When supervision by a qualified counselor is not possible on a monthly basis, the counselor or the person providing counseling supervision should meet with the clinic supervisor to discuss/plan how to support the counselor between supervisory visits.
- For quality of counseling services to be maintained, supervision is absolutely essential.

Inadequate Skills to Meet Work Responsibilities or Excessive Expectations

Many clinics may find it difficult to recruit fully qualified counselors. This combined with the efforts to give community members greater roles in the project may mean that counseling positions are filled by people who do not have the amount of training and experience needed to fulfill counseling responsibilities and meet standards.

Lack of training and experience can cause counselors to have unrealistic expectations for counseling and for themselves as counselors. Under-skilled counselors find many situations for which they are not prepared. Both counselors and clients may feel frustrated. All of this can lead to burnout.

POSSIBLE SOLUTIONS:

- Revise expectations for the position.

- Clinics that are recruiting counselors with training and experience that does not meet the expected qualifications for Avahan counselors may need to revise and simplify the counseling job description accordingly. Clear expectations for the work and the type/amount of support that will be given should be shared with the person/s in the counseling position.
- Build capacity.
- Each clinic should work with the state-led partner and the counseling supervisor to develop an ongoing capacity building plan for the counselor. This should include basic training appropriate to job expectations, refresher training, on-the-job training, mentoring by a supervisor during regular supervisory visits, and participation in workshops and meetings that are appropriate for their level of skills.

Lack of Support from Colleagues/Team

Often the counselors' roles and counseling as a service are not understood by their colleagues, so their work is not valued or appreciated. Some colleagues may think that the counselors are getting paid to just "talk."

POSSIBLE SOLUTIONS:

Every STI clinic should orient staff and volunteers to the roles and responsibilities of each member on the team. When needed, counselors drawn from HRG communities should be assisted to prepare for and contribute to team meetings for discussion of difficult cases. During planning meetings, the specific responsibility of each team member should be clearly identified. Clinic managers are to guide team planning and ensure that all contributions are recognized.

Lack of infrastructure may also create problems for counselors and counseling.

Counseling services are to be provided in a closed space with both auditory and visual privacy. Some clinics are quite small. A counseling space may need to be created by walling off a small space. Such spaces may lack ventilation and can be very hot.

During outreach clinics, there is often no possibility of creating a private space for counseling. Client records for any repeat clients will not be available in outreach settings. Counselors will not be able to meet counseling expectations unless a client can be convinced to come to the clinic. A clinic's client records may not be readily available for counselors to use, or there may not be a locked space to keep these in.

What can counselors do to prevent burnout?

Some personal coping strategies for the counselors to overcome burnout and occupational stress include:

- Be aware of the problem.
- Remember that one can only help another person, but cannot take responsibility for that person.
- Identify and accept one's own limitations.
- Remind oneself that HRG clients have many strengths and have coped before.
- Develop self-control, use humor, learn from mistakes, and share frustration.
- Pay more attention to positive events and contributions than to negative ones.
- Lifestyle management:

- Do stress-reducing activities such as yoga, breathing exercises, walking, or a regular physical activity or sport.
- Learn a new activity or hobby.
- Spend time with friends and family without talking about work problems.

Sometimes, counselors may decide that professional counseling would help them. Counselors who believe in their work and understand the importance of their contribution will seek help when they need it.

Supervisors will also help counselors make their own stress management plan, using personal resources from inside and outside the clinic. For example, counselors may be assisted in thinking about their network of colleagues, friends, family, and supervisors to see how they can meet the following needs:

- sharing their work issues in a confidential manner
- obtaining feedback/guidance
- developing professional skills, ideas, and information
- venting emotions if they are angry, fed up, or discouraged
- acknowledging feelings including those of distress, pleasure, and failure
- feeling valued by their colleagues and supervisors
- increasing their physical, emotional, or spiritual well-being

Annex 6

6.1 STI/HIV Counseling Service Data Collection Form/Register

Date of service									
ID Number									
Client Name									
Client Age									
Sex/gender	Male/Female/Transgender								
Marital Status	Married (M)								
	Unmarried (UM)								
	Living with regular partner (P)								
Referred By	Outreach worker (ORW)								
	Peer educator (PE)								
	Other (O)								
Category	Men who have sex with men (MSM)								
	Transgender (TG)								
	Sex worker (SW)								
	Injecting drug user (IDU)								
	Truck driver (TD)								
Services Provided	Risk assessment/risk reduction plan (RA/RRP)								
	Condom teaching (CD)								
	Promote speculum examination (S)/rectal examination (R)								
	Promote syphilis screening (SS)								
	Promote regular monthly checkups (RMC)								
	STI treatment counseling (ST)								
	Promote HIV testing								
	HIV pre-test counseling								
	HIV post-test counseling								
Referral Services	RPR/other syphilis testing/STI referrals								
	HIV testing								
	HIV care and support services (HCS)								
Follow Up	Promote follow-up counseling (FU)								
DNV	Set a date for next visit								

Family Health International/India
16, Sunder Nagar
New Delhi 110003
India

Tel: 91-11-4304 8888
Fax: 91-11-2435 8366
Email: fhiindia@fhiindia.org