HIV Voluntary Counseling and Testing in Egypt

A Reference Guide for Counselors

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BSS	Behavioral Surveillance Survey
CDC	Centers for Disease Control
CSW	Commercial Sex Worker
ELISA	Enzyme-linked Immunosorbent Assay
FHI	Family Health International
FP	Family Planning
IDU	Injecting Drug User
IEC	Information, Education and Communication
IMPACT	Implementing AIDS Prevention and Care Project
HPV	Human Papilloma Virus
HIV	Human Immunodeficiency Virus
M&E	Monitoring and Evaluation
MOHP	Ministry of Health and Population
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
NAP	National AIDS Program
OIs	Opportunistic Infections
PCR	Polymerase Chain Reaction
PCP	Pneumocystis pneumonia
PEP	Post-Exposure Prophylaxis

PLHA	People Living With HIV/AIDS
RIPA	Radioimmunoprecipitation Assay
STI	Sexually Transmitted Infection
TB	Tuberculosis
USAID	United States Agency for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Definitions

Acquired Immunodeficiency Syndrome (AIDS): A collection of symptoms and infections resulting from the depletion of the immune system caused by HIV.

Anonymous Testing: HIV testing in which the blood sample and test results are identified only by code, not by name, with no identifying markers to link the sample to the client. Anonymous testing is known to increase clients accessing VCT, especially amongst already marginalized individuals, who would otherwise not be tested. This type of testing prompts earlier entry into medical care.

Antibody: A protein substance produced in the blood or tissues to protect against infection in response to a specific antigen.

Antigen: A substance that when introduced into the body stimulates the production of an antibody. Antigens include toxins, bacteria, viruses, foreign blood cells and the cells of transplanted organs.

Antiretroviral (ARV): An effective agent against retrovirus such as HIV.

CD4: A marker found on the surface of some white blood cells that serves as the receptor for HIV. All cells with that marker are called CD4 cells.

CD4 cells Count: The number of CD4 cells in a cubic millimeter of blood, indicating the strength of a person's immune system. As HIV destroys CD4 cells, the infected person's immune system is weakened. By measuring the CD4 cell count, it is possible to determine the stage of HIV disease and to predict the risk of complications.

Confidential Testing: HIV testing in which some identifying information may be collected, however only the client and the counselor involved in the client's direct care know that the test was performed and have access to the results. All medical records should be managed in accordance with appropriate standards of confidentiality. Only health workers with a direct role in the management of patients should have access to medical records.

ELISA: Enzyme-linked immunosorbent assay is a screening test used to detect whether a person is infected with HIV by identifying the presence of antibodies in the blood sample.

Human Immunodeficiency Virus (HIV): HIV belongs to the retrovirus family of viruses. Retroviruses are living micro-organisms that cannot reproduce in isolation. In the case of HIV, it preferentially infects a subset of white blood cells (CD4 cell) that are fundamental in the immune defense system of the human body.

HIV Counseling: The process by which an individual undergoes counseling enabling him or her to make an informed choice about being tested. This process is aimed at helping them to cope with stress of being tested, providing support when receiving the test result and assists individuals in making personal decisions related to HIV/AIDS.

HIV Testing: The process by which blood or body fluids are analyzed for the presence of antibodies or antigens produced in response to HIV. HIV testing should be undertaken with informed consent and be voluntary.

Informed Consent: Consent by a patient or client to a surgical, medical or psychological procedure or participation in a clinical study after achieving an understanding of the relevant medical facts and the risks involved.

Lesions: Abnormalities involving tissues or organs due to a disease or injury.

Mother-to-Child Transmission (MTCT): A mother can transmit HIV infection to her child during pregnancy, delivery or through breastfeeding.

Opportunistic Infection (OI): An infection that occurs because of a weakened immune system. OIs usually do not cause disease in a person with a healthy immune system, but can affect people with a poorly functioning or suppressed immune system and, therefore, are a particular danger for people with AIDS.

Palliative Care: Treatment to alleviate symptoms without curing the disease.

Post-Exposure Prophylaxis (PEP): Taking antiviral medications as soon as possible after exposure to HIV, so that the exposure will not result in HIV infection.

Protocol: The plan for a course of medical treatment, medical procedure or for a scientific experiment.

Referral: The process by which immediate client needs for care and support services are assessed and prioritized and clients are provided with assistance in accessing services (setting up appointments, providing transportation, etc). Referral should also include follow-up efforts necessary to facilitate initial (and sometimes ongoing) contact with care and support service providers.

S**ero-conversion:** Development of detectable antibodies in blood serum as a result of infection.

Serology: The science that deals with the properties and reactions of sera, especially blood serum.

Sexually Transmitted Infection (STI): An infection that can be transferred from one person to another through sexual contact.

Ulcer: An area of erosion of the skin or an organ. The ulcer is concave and depressed below the level of the surrounding tissues.

Universal Precautions: Protective measures that can be followed to prevent contact with body fluids of another person who may or may not have a communicable disease or infection. Precautions are especially applicable in the diagnosis and care of AIDS patients.

Viral load: The amount of HIV in the person's blood. HIV viral load is increasingly employed as a marker for disease progression.

Viral Replication: The action or process of a virus reproducing or duplicating.

Voluntary HIV Testing: Is the process by which individuals seek testing based on their personal choice and free of coercion.

Voluntary Counseling and Testing (VCT): VCT consists of pre-test counseling, testing, post-test counseling and follow-up support (as required). VCT is delivered by trained HIV/AIDS counselors who help clients understand the experience of being tested, the choices to be made thereafter and the various support services that might be helpful.

Western Blot: An HIV test used to confirm the results of an ELISA. It can rule out false positive HIV results.

Preface

Egypt occupies a strategic location in the Middle East Region at the intersection between Europe, Africa and Asia. The country occupies the northeastern part of the African continent with the Sinai Peninsula in Asia. The total population of Egypt is estimated at 77 million with roughly one quarter residing in Greater Cairo. Approximately 14 million Egyptians are between 15-24 years of age (UNDP, 2003). Research conducted among high-risk groups, showed a significant number of sexually transmitted infections (STIs) among these populations. The prevalence rate of STIs, combined with the existence of various high-risk groups, including injecting drug users (IDUs), men who have sex with men (MSM) and commercial sex workers (CSWs), portray the need for targeted Human Immunodeficiency Virus (HIV) prevention activities.

Additional factors which could eventually fuel the transmission of HIV include the fact that Egypt is one of the eminent destinations in the region receiving tourists from all over the world. Also, the country shelters thousands of refugees and attracts people who want to receive quality education and medical care from surrounding Middle Eastern, African and Asian countries. An estimated two million Egyptians work abroad, especially in the oil producing Arab countries. In addition, there is an increasing number of Egyptians traveling abroad for short periods (El-Sayed N., et al., 2003). All of these factors put the country at high risk of HIV infection and transmission.

HIV and Acquired Immunodeficiency Syndrome (AIDS) started to appear in Egypt in 1986 when the first case was detected. According to the Egyptian Ministry of Health and Population (MOHP) Report dated December 2005, 2330 cases have been detected; of these 1,680 were Egyptians and 650 were foreigners. Of the 1,680 Egyptians 535 cases have developed AIDS, while 1,145

remained asymptomatic HIV cases (NAP, 2005). Heterosexual transmission was the most common mode of transmission, accounting for 47.2% of the HIV/AIDS cases in Egypt, followed by infection through blood/blood products and hemodialysis, accounting for 22.9% of cases and homosexual sex accounting for 21% of the cases. Intravenous drug use was responsible for 2.2% of the HIV/AIDS cases. In 5.5% of cases, the mode of transmission was unidentified. Males were five times more at risk than females, keeping vertical transmission through mother to child at 1.2% (NAP, 2005).

Prevention of HIV/AIDS has been identified as a priority by the government of Egypt. Even though the prevalence appears to be low at this time, efforts are required to contain the epidemic. The MOHP has made considerable progress in establishing anonymous voluntary counseling and testing (VCT) services and in building the capacity of counselors and other service providers to deliver comprehensive prevention, care and support services. Establishing VCT services provides an opportunity for individuals to know their HIV sero-status. It is also an important entry point for:

- Early management of opportunistic infections (OIs) and STIs
- Preventive therapy (tuberculosis [TB] and pneumonia)
- Referral to social services and peer support
- Normalizing HIV/AIDS (stigma & discrimination)
- Family planning and contraceptive services
- Planning for the future (care of orphans)
- Reducing mother-to-child transmission (MTCT) of HIV

The MOHP sincerely hopes that counselors and other care providers will use this guide:

- As an ongoing resource in delivering high quality, HIV/AIDS related counseling services to the people of Egypt.

- To apply newly acquired knowledge in their workplaces and communities.
- To continue to build the capacity of other service providers in order to prevent further transmission of HIV.
- To provide care and support for Egyptians living with HIV/AIDS.
- To encourage the development and use of a range of referral services and networks to enhance service provision.

Chapter 1

Basic Information on HIV/AIDS

Basic Information on HIV/AIDS

What is HIV?

Human Immunodeficiency Virus (HIV) is the virus that causes AIDS. Two types of HIV are currently known: HIV-1 and HIV-2. Worldwide, the predominant virus is HIV-1. Although cases of HIV-2 have been reported in several parts of the world, it is predominantly found in West Africa. Both types of the virus are transmitted by sexual contact, through blood and from mother to child during pregnancy, delivery, and/or breastfeeding. HIV-1 and HIV-2 cause clinically indistinguishable AIDS. However, HIV-2 is not as easily transmitted and the period between initial infection and illness is longer. Cases of concurrent infections with the two viruses have been described, predominantly in West Africa.

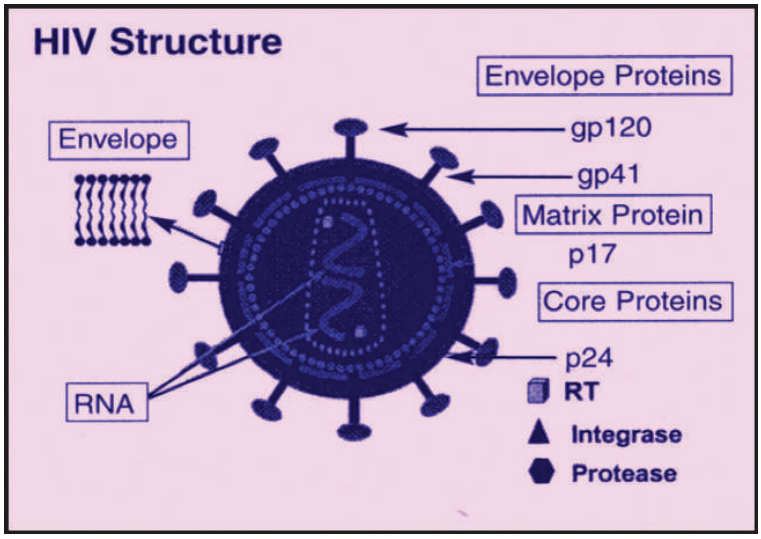


Figure 1: The Human Immunodeficiency Virus

HIV belongs to the retrovirus family of viruses. Retroviruses are living micro-organisms that cannot reproduce in isolation. In the case of HIV, it preferentially infects a subset of white blood cells (CD4 cells) that are fundamental in the immune defense system of the human body.

HIV may remain dormant for months or years. However, as time goes by the CD4 infected cells are progressively destroyed. Any other infection, which activates the immune defense system, is likely to accelerate this destruction as the activation of the immune system is accompanied by viral replication. When the CD4 cells are destroyed to a significant degree, the ability of the infected person to fight off infections is decreased. This makes the person more vulnerable to opportunistic infections and cancers and more likely to develop AIDS.

What is AIDS?

AIDS stands for Acquired Immunodeficiency Syndrome. “Acquired” means not intrinsic or inherited but transmitted from person to person; “Immune” is the body’s system of defense; “Deficiency” means not working to the appropriate degree; and “Syndrome” means a group of signs and symptoms.

AIDS is the advanced stage of HIV infection. It is a disabling and lethal disease caused by HIV. AIDS is diagnosed when an HIV-positive person presents with a syndrome characteristic of severe immune depression. Multiple diseases and clinical problems are common in AIDS, and in the absence of specific therapy, death generally occurs. Progression of HIV infection to AIDS depends on the type and strain of the virus and certain host factors. Factors that may cause faster progression include a person's age (younger than five or over 40 years), the presence of other infections, the HIV virus type and possibly genetics (hereditary factors). As HIV infection

progresses and immunity declines, people become more susceptible to OIs. These include:

- TB
- Other STIs
- Septicemia
- Pneumonia (usually Pneumocystis carinii)
- Recurrent fungal infections of mouth and throat
- Meningitis
- Other skin diseases (e.g., Kaposi's sarcoma)

HIV wasting, defined as unintended and progressive weight loss often accompanied by weakness, fever, nutritional deficiencies and diarrhea, can diminish the quality of life, exacerbate illness and increase the risk of death for people with HIV. Chronic or intermittent fever, chronic or intermittent diarrhea, and severe weight loss, and TB are the most common problems in many people living with HIV/AIDS (PLHA). The higher the viral load (amount of virus in the body) and the lower the CD4 cell count, the higher the chance of death. Death may be due to HIV or to OIs (particularly those that affect the brain, heart, or lungs).

Epidemiological Data

According to the Joint United Nations Programme on HIV/AIDS, more than 25 million people have died from AIDS since it was first recognized in 1981 (UNAIDS, 2005). Despite recent improved access to antiretroviral treatment and care in many regions of the world, AIDS claimed 3.1 million lives in 2005; more than half a million were children (UNAIDS/WHO, 2005).

Table 1: Epidemiological Data

	Number of people living with HIV in 2005	People newly infected with HIV in 2005	No. of women (15-49 years) living with HIV in 2005	AIDS deaths in 2005
Worldwide	40.3 million	4.9 million	17.5 million	3.1 million
Middle East and North Africa	510,000	67,000	220,000	58,000

Source: UNAIDS/WHO 2005

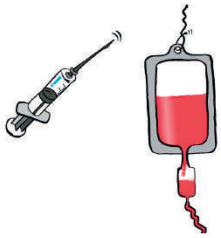
Modes of Transmission of HIV

HIV is transmitted via the following body fluids:

- Blood
- Vaginal fluids
- Semen
- Breast milk

HIV can be spread from infected individuals to others via:

- Sexual transmission



- Transmission through infected blood

- Mother to Child Transmission (MTCT)

HIV is **NOT** transmitted via:

- Casual contact such as shaking hands, hugging, touching, or kissing
- Sharing eating or drinking utensils
- Toilets or swimming pools
- Tears, sweat and saliva
- Insects (such as flies and mosquitoes)

Counselors should be aware that while most clients have some knowledge of the modes of transmission and the different levels of risk that they pose, it is important to assess the level of each client's understanding individually and to impart relevant information depending on the client's needs and level of knowledge. It is very important that counselors encourage clients to make informed decisions about testing and behavior change (based on a clear understanding of modes of transmission, perception of risk, and possible implications of the test results), and correct clients misconceptions.

Sexual transmission

It is estimated that 70 percent to 80 percent of global HIV transmission occurs between infected persons and their partners through unprotected sexual intercourse. The sexual contact may be heterosexual or homosexual. While the probability of transmitting HIV in a single sexual act is low, several factors increase the risk of infection dramatically, including the presence of a prior STI (sometimes manifested in genital ulcer or discharge) and having multiple sexual partners.

Transmission through infected blood

Transmission through infected blood accounts for between 5–10 percent of all HIV infections. Transmission occurs through transfusion with contaminated blood or blood products, contaminated injecting equipment (exchange and reuse of needles or contaminated syringes), and surgical

operations where equipment previously used with an HIV-infected patient has not been adequately sterilized. Organ transplants from infected donors can transmit the infection as well. HIV infection can also be transmitted through direct contact with materials that have been contaminated with infected blood during rituals such as circumcision and tattooing and not sterilized before reuse.

Mother-to-child transmission (MTCT)

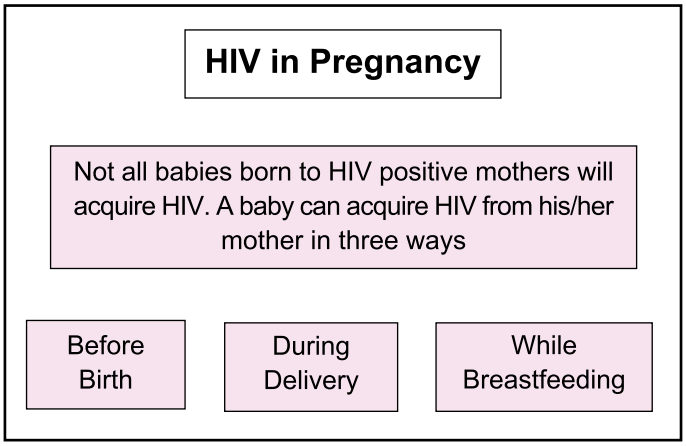


Figure 2: HIV in Pregnancy

A mother can transmit HIV infection to her child during pregnancy or delivery, or through breastfeeding. Rates of HIV-1 transmission from mother to child range from 15 percent to 40 percent (FHI, 2004). Risk of transmission is affected by factors related to the virus, the mother, the delivery process, the infant, and how the infant is fed.

During pregnancy and delivery, the mother's health, disruption of the placental barrier, pre-term delivery, and hemorrhage are significant predictors of the child's infection. Other factors that increase the opportunity for transmission during this period include viral, bacterial, or parasitic placental infections.

Most infants who acquire HIV during delivery have been exposed to maternal blood or cervical secretions that contain HIV. Prolonged membrane rupture and invasive delivery techniques also have been associated with higher risks of MTCT during labor and delivery. The risk of MTCT increases if a woman has a higher viral load, which occurs if she becomes infected or re-infected with HIV during pregnancy or if she becomes ill with AIDS.

Following delivery, breastfeeding is the most important risk factor. Without treatment, an estimated one out of every seven infants breastfed by an HIV-positive mother becomes infected through breast milk. The World Health Organization's (WHO) standard recommendation is ideally to promote replacement feeding when it is accessible and feasible and good hygiene can be insured. The MOHP recommends that HIV-positive women should avoid breastfeeding their infants.

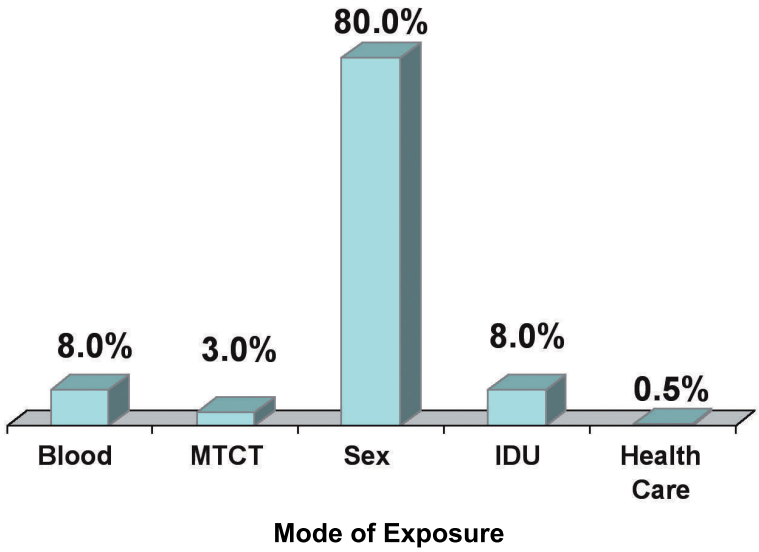


Figure 3: Global HIV Infections by Mode of Exposure

Methods of Risk Reduction

Changing sexual behavior

The most common mode of HIV transmission is unprotected sexual intercourse. Precautions that should be taken to reduce the risk of sexually acquired HIV are:

- Abstain from sex until marriage.
- Be faithful, practice fidelity in marriage and other sexual relationships.
- Reduce the number of sex partners.
- Use a condom or latex barrier consistently during sexual contact.
- Avoid sex with people who may have multiple partners or are engaging in other high-risk activities, such as commercial sex or injecting drug use.
- Get treated for other STIs.

Reducing the risk of mother-to-child transmission

Currently there are five known approaches for reducing the risk of MTCT:

- Primary prevention of HIV infection.
- Reducing unwanted pregnancy in HIV-positive women.
- Reducing risk during pregnancy.
- Reducing risk during labor and delivery (e.g., optimal obstetric care, antiretroviral medicine).
- Safer infant feeding options.

Safer use of injection equipment

Anyone who shares injectable needles for drugs, insulin, steroids, and/or tattooing may be at risk for HIV infection. Infected blood left in the needle contains HIV, and when needles are re-used this blood and the HIV enter

the second user's bloodstream. Clients can reduce their risk of HIV from unsafe injecting practices by:

- Abstaining from injecting drugs.
- Abstaining from sharing needles, syringes, cookers, and other injecting equipment.
- Using new needles with each injecting experience.

Universal precautions to prevent HIV transmission in health care settings

The phrase "universal precautions", refers to protective measures that can be followed to prevent contact with body fluids of another person who may or may not have a communicable disease or infection. Universal precautions are the standard practices used in the care of all patients to reduce the risk of transmission of infections spread by blood and certain body fluids. Universal precautions for HIV are based on the simple fact that there is no way to be certain whether another person is infected; therefore, it is safest to handle everyone's blood and body fluids as if they were infected. Prevention to avoid transmission pertains to most body fluids, such as blood, blood products, semen, and vaginal fluids (including menstrual blood). Saliva, urine, feces, and mucus may also contain blood, whether or not it is visible.

Basic universal precautions that everyone should follow include:

- Avoid unprotected contact with all blood and body fluids.
- Use a barrier as well when applying a bandage or gauze to a cut or scrape, or when attempting to stop bleeding after an accident or injury. Do not let anything touch the part of the bandage or gauze that will cover the cut.
- Discard or decontaminate anything that has had direct contact with blood or body fluids, such as bloody tissues, paper towels, or gauze. Wash any bloody clothes first in hot water and bleach, then in detergent.

- Do not share knives or razors used for traditional rituals that involve blood (including tattooing, circumcision, skin cutting, etc.).
- Handle and dispose of "sharps" carefully (i.e., used needles, etc.).
- Wear gloves during any contact with body fluids, skin or mucosal lesions, and/or contaminated or potentially contaminated materials
- Cover all wounds.
- Wash hands immediately after contact with potentially contaminated materials and after every health care procedure.
- Wear protective clothing when there is a risk of splashing.
- Disinfect soiled instruments and surfaces immediately with a fresh 1:10 solution (i.e., one part bleach or other disinfectant to ten parts water).
- Place samples in airtight and labeled tubes, flasks, or packaging.
- Arrange to incinerate contaminated materials.

Post-exposure prophylaxis

Post-exposure prophylaxis (PEP) means taking antiviral medications as soon as possible after exposure to HIV, so that the exposure will not result in HIV infection. Provision of antiretroviral drugs for PEP for all phlebotomy staff is important in case of any potential exposures, such as needle stick injuries.

Immediately following any exposure, whether or not the source is known to pose a risk of infection, the site of exposure (i.e., wound or intact skin) should be washed liberally with soap and water, but without scrubbing. Exposed mucous membranes, including conjunctivae, should be irrigated abundantly with water, before and after removing any contact lenses.

The issuing of PEP should be considered after an exposure with the potential to transmit HIV and hepatitis, based on the type of body fluid or substance involved and the route and severity of exposure.

Post-exposure prophylaxis should be started as soon as possible after potential exposure to HIV. The medications used in PEP depend on certain aspects of the exposure to HIV.

The following situations are considered serious exposure:

- Exposure to a large amount of blood.
- Blood coming in contact with cuts or open sores on the skin.
- Blood visible on a needle that stuck someone.
- Exposure to blood from someone who is HIV positive.

For serious exposures it is recommended to use a drug combination of more than two approved antiviral drugs for four weeks. For less serious exposure, four weeks of treatment with two ARV drugs is recommended.

Progression of HIV infection

Several phases occur between the time HIV infects a person and the advent of AIDS. After exposure to the virus and viral replication, an infected person passes through an asymptomatic phase which, on average, lasts around 8 years. During this phase, a person's immune system progressively breaks down and becomes vulnerable to opportunistic infections. Through currently available treatment, the natural progression of HIV infection can be modified considerably. Prevention and correct management of opportunistic infections have a beneficial effect on the progression of HIV infection. Where available, antiretroviral treatment of HIV infection generally slows disease progression and improves the quality and length of life.

Natural history of HIV infection

Once HIV enters a person’s body:

- HIV infects and replicates in the person’s cells (mainly CD4 cells).
- Significant viral replication induces the immune system to produce antibodies to HIV.

The period between acquisition of infection and production of antibodies, also called “sero-conversion,” usually lasts between 2 and 12 weeks but may continue for as long as six months. This is also known as the “window

period." During this time, a person is infectious but may not test positive on HIV antibody tests.

- At the time of infection, a small number of people may have a recognizable acute illness, with symptoms such as fever, lymphadenopathy (enlarged lymph nodes), night sweats, skin rash, headaches, and cough. These symptoms are usually ignored and/or passed off as general flu-like symptoms or as malaria in malaria endemic areas.
- After sufficient induction of the antibody response, viral replication is kept in check. The infected person is asymptomatic (symptom-free) and may remain so for a period varying from a few weeks to 10 years or more.
- After a time, which varies from one individual to another, viral replication resumes and intensifies. Other infections may play a role in facilitating viral replication.
- Viral replication leads to destruction of CD4 cells and progressive immunodeficiency.
- As immune depression progresses, the infected person becomes susceptible to opportunistic infections. Clinical syndrome at this stage depends on the level of immune depression and on previous or current exposure to antiretroviral drugs.
- AIDS is diagnosed when an infected person presents syndromic characteristics of severe immune suppression.

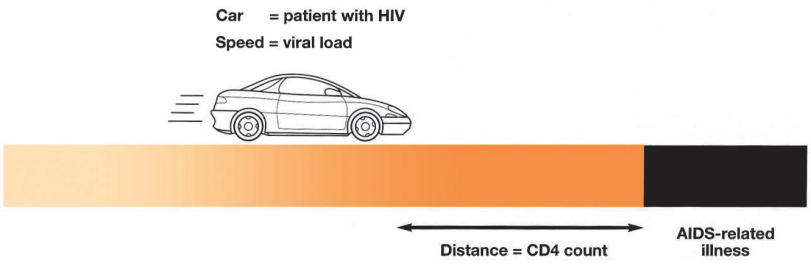


Figure 4: HIV Disease Progression

Summary

- A person does not develop AIDS as soon as he/she becomes infected with HIV.
- There is often a lengthy period between HIV infection and the development of AIDS, averaging from 5 to 10 years (as depicted by the distance the car travels in the previous diagram). During most of this period people may not have any symptoms; many may not even be aware that they are infected. During this "silent" phase, a person may unknowingly transmit infection to others.
- Viral and host factors, including the presence of other infections and nutritional status, help determine the different rates at which people develop AIDS.

Diagnosis and Clinical Staging

Clinical diagnosis of HIV infection is based, most often, on blood testing designed to reveal the presence of HIV antibodies in a patient's blood. For people who present with clinical symptoms, diagnosis is usually based on the WHO clinical staging system: a four-stage classification system that combines signs, symptoms, and diseases, plus a physical activity framework using a performance scale. Patients are classified according to the presence of clinical conditions and/or performance scores belonging to the highest stage. The staging is hierarchical, and once a stage is reached, the patient cannot revert to a lower stage; he/she can only progress to a higher stage. Although counselors are not expected to make diagnoses, they must be aware of clinical staging to facilitate referral to medical providers.

Table 2: WHO Clinical Staging System for HIV Infection and Disease

Stage 1	Asymptomatic or lymphadenopathy (enlarged lymph nodes)
Stage 2	Weight loss < 10 percent Varicella zoster viral infection Recurrent minor illnesses Activity scale: Normal
Stage 3	Weight loss > 10 percent Fever or diarrhea for longer than one month Oral candidiasis Pulmonary TB in past year Severe bacterial infections Activity scale: In bed < 50 percent of days in past month
Stage 4	HIV wasting syndrome Non-typhoid salmonella septicemia Wide range of specific OIs Activity scale: In bed > 50 percent of days in past month

What is a CD4 cells count?

The CD4 cells count, a measurement of a person's CD4 cells, is a marker of the strength of a person's immune system. As HIV destroys the CD4 cells, the infected person's immune system is weakened. By measuring the CD4 cells count, it is possible to determine the stage of HIV disease and to predict the risk of complications (certain AIDS-related medical conditions occur at particular stages of HIV disease). Thus, the CD4 cells count can be used to identify problems for which an individual may be at risk and to determine what medications might be helpful.

What is viral load?

Viral load is the amount of HIV in a person's blood. Like CD4 cells counts, measuring viral load is important for disease staging and prognosis. Persons with a high viral load are more likely to progress rapidly to AIDS than are persons with lower loads of the virus.

How are the CD4 cells count and viral load related?

The CD4 cells count is a marker of the level of the person's immune function at any given time, while the viral load is a measurement of the level of circulating virus in the blood. As the virus reproduces, it destroys CD4 cells and reduces the CD4 cells count. In general, the higher the viral load (the amount of virus in the body), the lower the CD4 cells count (the more quickly the CD4 cells will be destroyed). See the following diagram for a graphic depiction of the interrelation between the CD4 cells count and the viral load. Both tests are useful in helping clients make informed decisions about care including guiding the use of antiretroviral therapy, staging HIV disease, and determining prognosis (predicting complications).

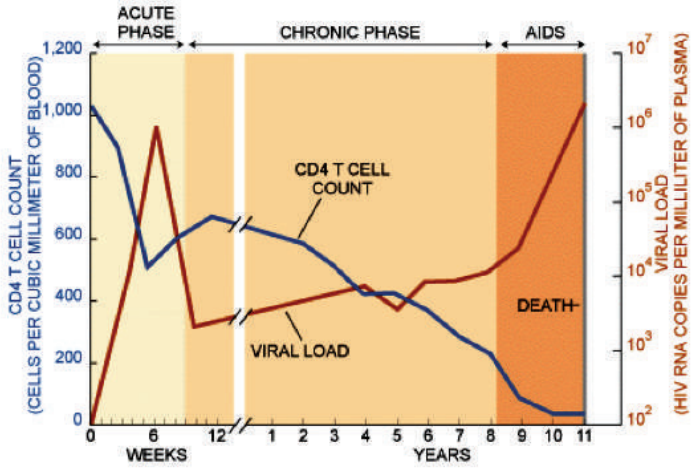


Figure 5: The Natural Course of HIV Infection

The Relationship between HIV/AIDS and Other STIs

Like HIV, STIs are infections contracted principally through sexual intercourse. Some of the most common are:

- Gonorrhea
- Syphilis
- Genital herpes
- Chlamydia
- Human Papilloma Virus (HPV)
- Trichomoniasis

Sexually transmitted infections can have serious consequences if left untreated. Sexually transmitted infections are also a powerful co-factor for transmitting or acquiring HIV infection. The presence of STIs increases a person's vulnerability to acquiring HIV by 15 and 20 percent. The presence of STIs, particularly if they are ulcerative, increases one's risk of contracting HIV infection because they may cause cracks or micro-lesions in the mucous membrane. The presence of genital lesions or inflammation (caused by STIs) enables HIV to enter and establish itself in the body. Therefore, to reduce the risk of HIV infection, it is crucial to avoid contracting other STIs. If other STIs do occur, prompt and effective treatment is imperative to minimize the risk of acquiring or transmitting HIV.

There is a strong connection between the presence of another STI and HIV infection, and one STI can hide another. In fact, all cases of STIs should be considered as possibly indicating the presence of HIV infection. Correct treatment of STIs contributes to the control of HIV transmission, and prevention of STIs can help prevention of HIV infection.

In 1999, a study was conducted to measure the prevalence of gonococcal, chlamydial and trichomonal infections and syphilis seroprevalence among selected Egyptian population groups living in greater Cairo. This study is

considered the first study conducted in Egypt targeting high-risk groups and using golden standards in laboratory techniques for STI diagnosis. Results of this study are being used in the development of National Sexually Transmitted Infections Diagnosis and Treatment Guidelines for clinical care providers (El-Sayed N., et al., 2002).

Table 3: Prevalence of Sexually Transmitted Infections in Selected Populations in Greater Cairo

	Prostitutes (n=52) %	MSM (n=80) %	Drug users (n=150) %	ANC (n=604) %	FP (n=108) %
Syphilis (TPHA)	5.8	7.5	1.3	0.0	0.0
Gonorrhea	7.7	8.8	2.7	2.0	2.8
Chlamydia	7.7	8.8	2.7	1.3	2.8
Trichomoniasis	19.2	1.3	0.7	0.7	2.8
Any STI*	36.5	23.8	5.3	4.0	8.3

* One or more STI p = 0.000 n = sample size
Source: El Sayed N., et al., 2002

Care and treatment of STIs

The care and treatment of STIs should include:

- Correct early diagnosis followed by treatment with antibiotics
- Counseling and education for behavior change
- Treatment of all partners (sexual contacts)

Recommendations for STIs

For the client:

- Avoid self-medication (encourage clients to seek medical attention)
- Inform all partners of the infection and how to receive treatment
- Abstain from sexual contact during treatment or use condoms

For the health provider:

- Educate clients about STIs
- Educate about partner medication
- Assist in partner referral
- Inform clients of the increased risk of contracting HIV

Chapter 2

Overview of VCT

Overview of VCT

Voluntary counseling and testing is a key entry point to prevention services in populations at risk and to care and support for PLHA, and therefore benefits those who test positive, as well as those who test negative. Determining sero-status through counseling and testing must be promoted in Egypt if HIV prevention is to be truly effective. Knowing one's HIV infection status strengthens prevention efforts by encouraging infected persons to avoid ongoing transmission to others and motivating those who are not infected to protect themselves through risk reduction strategies and behavior change. HIV counseling and testing can lead to a reduction in the number of sexual partners, increased condom use, fewer STIs and safer injecting practices.

Voluntary counseling and testing services allow clients the opportunity to utilize anonymous pre-test and post-test counseling services when considering an HIV test, and to be linked to a range of care and support services that meet their needs. HIV testing includes access to screening and confirmatory testing using rapid tests, sophisticated Enzyme-linked Immunosorbent Assay (ELISA) and Western Blot technology. The procedures for conducting VCT should be reviewed and updated regularly in the context of changes in national and/or legal policies and/or situational changes that relate to HIV/AIDS in Egypt.

Voluntary counseling and testing has long been a component of HIV prevention and care efforts. Major roles for VCT include:

- Enabling VCT clients to cope and make personal decisions related to HIV/AIDS.
- Assisting VCT clients to initiate and maintain preventive behaviors.

- Serving as an entry point to other HIV prevention and care and support services.
- Helping to combat stigma and discrimination in the community.

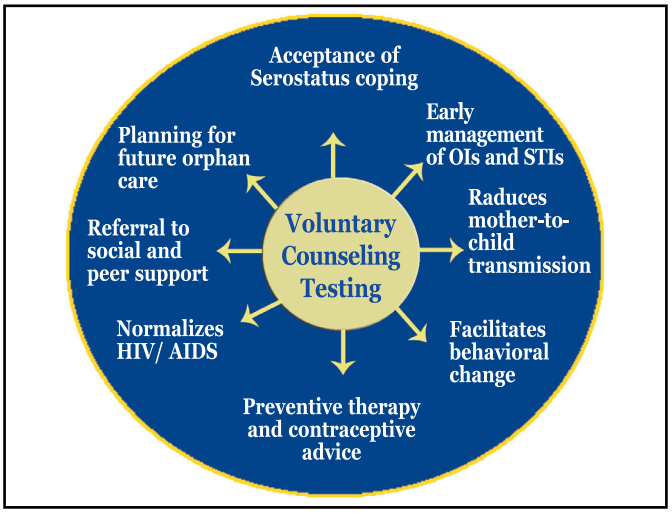


Figure 6: VCT - An Important Entry Point for HIV Prevention and Care

Most VCT programs are guided by the following principles:

- Aim for high-quality VCT
- Obtain equity and equal access for all people demanding VCT services
- Allow referral and access to a comprehensive range of prevention, care and support services
- Advocate for cost-efficient services for clients
- Aim for sustainable services with a focus on health impact
- Foster community ownership of VCT services

Voluntary counseling and testing must be of the best quality, and available and easily accessible to those who need such a service. The existence of effective referral systems between VCT and other care and support services

in the community is critical in responding to the needs of people infected or affected by HIV/AIDS. In low prevalence settings such as Egypt, it is important for VCT services to target particular high-risk groups, possibly including:

- IDUs and their partners
- CSWs, their partners and clients
- MSM
- Street children and vulnerable youth

Chapter 3

Overview of Basic Counseling Skills

Overview of Basic Counseling Skills

Counseling is…

Counseling is an interaction in which the counselor offers a person the time/ attention/respect necessary to explore, discover, and/or clarify ways of living more resourcefully.

Counseling is a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS.

Counseling is an issue-centered and goal-oriented interaction.

for decision making and behavior change. Good counseling enables a person to be autonomous, i.e., able to choose, make decisions, and be responsible for his/her own actions.

Criteria of a Good Counselor

- A counselor is empathic – not disregarding nor detached.
- A counselor is unbiased/nonjudgmental/non-condemning.
- A counselor is objective – does not become emotionally involved (compassionate people need to guard against this).
- A counselor is realistic – he/she will not always get positive results.
- A counselor is authentic/genuine – not artificial, e.g., behaving like he/she is perfect or knows everything.
- A good counselor is open-minded – not defensive.
- A counselor is warm and friendly with a compassionate heart.
- A counselor is non-conditional, patient, self-controlled, calm, understanding, sincere, and reputable.

- A counselor dresses appropriately and uses positive humor.
- A counselor maintains flexibility and uses creativity, initiative, and knowledge.

Counseling is not…

- Counseling is not a conversation. It is not just people exchanging information and opinions.
- Counseling is not an interrogation. The client is not being questioned in order to find out the truth.
- The counselor does not use counseling as a forum in which to promote his/her own opinions.
- Counseling is not a confession. The client is not being morally pardoned or forgiven.
- Counseling is not a search for a diagnosis. The client is not questioned so that the counselor can find a label or diagnosis for his/her problem.
- Counseling is not information giving. The client does not come to the counselor solely for information, although information may be given. There is also a need for psychosocial support.
- Counseling is not advising. The counselor does not tell the client what to do.
- Counseling is not praying.

Elements of Good Counseling

Ample time

Providing the client with adequate time is important from the very beginning. The process of counseling cannot be rushed: time is necessary to build a helping relationship.

Acceptance

For a client to be honest during counseling, it is critical that he/she feels accepted. A nonjudgmental and accepting counselor can achieve this.

Counselors need to appreciate the stress caused by the fear of being infected or the need to change behavior, and accept the consequent emotions and reactions. To validate acceptance, the counselor needs to recognize feelings such as anger, sadness, and fear in a direct, unemotional way. The counselor must indicate to the client, in words and behavior, "Your feelings are very strong. I accept them, and I accept you."

Accessibility

Clients need to feel that they can ask for assistance or call on a counselor when needed. Counselors need to be available to clients at appropriate times and should have a system in place to respond to their clients' needs as appropriate (for example, provide after-hour services or work during lunchtime on a rotating basis).

Consistency and accuracy

Information provided through counseling (e.g., about HIV infection, HIV testing, risk of infection, and risk reduction) should be consistent both in content and over time.

Confidentiality

Trust is the most important factor in the relationship between counselor and client. It enhances the relationship and improves the odds that an individual will act decisively on the information provided. Given the possibility of discrimination, isolation, and the personal blame that may be faced by an individual diagnosed with HIV, it is very important to guarantee confidentiality.

Establishing rapport

Establishing rapport, or a trusting relationship, with clients is crucial and is a key element in facilitating a trusting working relationship. Developing rapport demonstrates the counselor's interest in and respect for a client's

issues and concerns. Building rapport is an ongoing process that can be facilitated by:

- A demonstration of respect and a nonjudgmental attitude.
- The presence of common or complementary goals.
- Open verbal and nonverbal communication.
- Mutual trust.

A useful technique in establishing rapport is asking questions that take into account the degree of importance of an issue, such as, “What's the worst thing that could happen?” or “If we could only deal with one thing today, what would be most important to you?” Such questions help define and prioritize a client's agenda and may be particularly appropriate to pose at the beginning of a session. Furthermore, through this process, the counselor is able to encourage the client to be explicit in describing sensitive issues, including sexual patterns of behavior. In this way, it may be possible for the counselor to determine the client's risk level accurately and to develop a realistic risk reduction plan.

Ensuring privacy and confidentiality

Contrary to previously held notions that confidentiality is a strictly Western concept, research indicates that clients everywhere need to be assured of privacy and confidentiality. Privacy and confidentiality can be ensured if the counselor:

- Provides adequate and appropriate space for counseling to take place.
- Understands that no information about a client can be disclosed without the client’s consent.
- Maintains adequate client records and takes all reasonable measures to preserve the confidentiality of the information.
- Takes steps to ensure that colleagues, staff members, and trainees understand and respect the need for confidentiality in counseling services.

- Is clear in describing or explaining to clients any boundaries or limitations of confidentiality if they apply in a specific country (such as case reporting to government sources or partner notification), as these often raise an ethical dilemma.

Showing respect

Counselors need to be aware that their own attitudes and actions can convey respect or lack of it. The following actions help to demonstrate respect for clients:

- Helping a client make informed decisions regarding his/her life and supporting him/her through the process (without telling him/her what to do).
- Keeping appointments and apologizing for lateness or the failure to keep an appointment.
- Being a “guide” not a “preacher”.
- Showing concern for a client’s welfare.
- Seeing each client as an unique individual.
- Seeing a client as capable of determining his/her own fate.
- Assuming a client's goodwill unless demonstrated otherwise.
- Expressing reasonable warmth and friendliness.
- Providing encouragement and support.

Genuineness

You are genuine or sincere in your relationship with your clients when you:

- Do not over-emphasize your professional role and avoid stereotyped ‘professional’ behaviors.
- Are spontaneous but not uncontrolled.
- Remain open and non-defensive even when you feel threatened.
- Are consistent and avoid discrepancies between your values and your behavior - be consistent about what you think and feel and what you say to the client.

- Are willing to share yourself and your experience with clients if this is seen as helpful.

Using appropriate language

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

- Uses simple and culturally appropriate language.
- Ensures that clients feel they are understood, and that a common level of communication is used.
- Explains important points more than once. If a counselor wants a client to leave with a particular message, the counselor should deliver the main message first, then deal with specific details, and finally, repeat the message in a summary.
- Puts important points in writing, when appropriate, or uses visual diagrams as memory aids, so clients can refer to the points after a session is over. Giving clients printed materials, such as pamphlets or brochures may also serve this purpose.

Counseling Skills and Techniques

Attending

The term “attending” refers to a counselor’s ability to pay close attention to the client by limiting distractions and demonstrating to the client that he/she is giving the client her/his full attention. Attending involves using responsive nonverbal skills such as listening, eye contact, relaxing, and using natural hand movements. Responding to the client by nodding affirmatively and using key words such as “yes,” “mm-hmm,” and “I see” when appropriate demonstrates attentiveness.

Maintaining eye contact shows that the counselor is engaged with the client, although clients who are annoyed, nervous, or embarrassed might try to avoid it. Maintaining eye contact will increase the client's confidence and facilitate better counselor-client communication. However, the counselor must distinguish between eye contact and staring, which can make the client feel uncomfortable.

In addition to using nonverbal skills, attending to the client is improved when the physical space is comfortable. The space can be improved by arranging a comfortable seating plan, with a culturally appropriate distance between counselor and client. Minimizing distractions, such as noises or disruptions, can also help create a facilitative atmosphere.

The following points need to be considered:

- Introduce yourself when greeting the client and explain your role.
- Provide a quiet room/space, free from interruptions.
- Adopt a comfortable seating arrangement with face to face contact.
- Adopt an open posture - this says that you are open to the client.
- Lean towards the client - this demonstrates your attentiveness and lets the client know that you are with him/her.
- Maintain good eye contact without staring, this tells the client of your interest in him/her and his/her concerns.
- Remain relatively relaxed with your client as you interact, this indicates confidence in what you are doing and helps the client relax.

Questions for the counselor to ask him/herself in relation to attending skills:

- What is my attitude towards this client?
- Is my non-verbal behavior showing a willingness to work with this client?
- What attitude am I expressing in my non-verbal behavior?

- What attitude am I expressing in what I say?
- Does the client feel that I am attending to him/her?
- In what ways am I distracted from giving my full attention to this client?
- What am I doing to handle these distractions?
- How can I present myself more effectively to the client?

Listening

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

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

- The client's experience: what the client sees as happening or not happening to him/herself.
- The client's behavior: what the client does or fails to do.
- The client's feelings: the emotions that arise from experience and behavior.
- The client's problems and worries: Ask the client to explain rather than assume you know.
- The counselor's own body language: gestures, facial expressions, pronunciation, distance, etc., that indicate he/she is listening and understands what the client is saying.
- The client's point of view when talking about his/her experience, behavior, and feelings.

Questions for the counselor to ask him/herself on listening skills:

- How well do I read the client's non-verbal behaviors and understand what he/she is saying verbally?
- How careful am I not to over-interpret non-verbal behaviors?
- How closely do I listen to what the client is saying verbally, noticing the mix of experiences, behaviors and feelings?
- How effectively do I listen to the client's point of view, especially when I sense that this needs to be challenged?
- How easily do I tune into the core messages being given out by the client?
- What distracts me from listening more carefully? What can I do to manage these distractions?
- How effectively do I listen to what is going on inside myself as I interact with my clients?

Immediacy

In the context of HIV counseling, "immediacy" refers to the ability of a counselor to deal with a situation affecting the way he/she and a client are relating at the given moment, for example, if the client is being aggressive towards the counselor. Immediacy involves the ability to:

- Reveal how another person is affecting you.
- Explore your own behavior towards the other person.
- Share observations about the other person's behavior towards you, or point out discrepancies or distortions.
- Invite the other person to explore the relationship with a view to improve it.

For example, if a client is slightly aggressive toward you, you may:

- Let the client know how you are being affected by what is happening in the relationship (that is, you share your experience).

- Explore how you might be contributing to the situation.
- Describe the client's behavior; share your thoughts about what is happening (challenge) and invite the client to examine what is happening in the counseling relationship.

Using impersonal statements

In making a general point, using impersonal statements (a skill also known as the "third-person technique") can be helpful in reflecting clients' feelings that are unspoken but nonetheless perceived. This technique is very useful in acknowledging, reflecting on, and normalizing the client's feelings and helps to avoid creating defensiveness in a client. Some examples of third-person statements include:

- "People can feel a lot of confusion and guilt when they hear information about HIV".
- "When I've given HIV test results to clients, sometimes they've wanted to talk about what they could do to keep themselves healthy and where they could go for help".
- "People often feel uncomfortable and guilty when you talk to them about HIV/AIDS".

Counselors can also use this technique to present choices as well, as in the following example:

- "Some people decide to abstain from sex, while others choose to remain faithful to one partner. Still others prefer to use condoms and some never use them. To avoid becoming infected with HIV, you must decide which of these options suits you best".

Asking open-ended questions

Asking clients open-ended questions gives them an opportunity to express themselves freely and makes it easier for the counselor to identify their needs and priorities. Open-ended questions are useful in starting a dialogue, finding

a direction, and/or exploring a client's concerns. However, long-winded, leading, or judgmental questions should be avoided. Questions that can be answered with a simple "yes" or "no" are not open-ended. The following are types of open-ended questions recommended for use in counseling sessions:

- How: "How do you think the virus is passed from one person to another?" "How much do you know about the risk factors or lifestyles of the people you are having sex with?"
- What: "What do you understand by the word, 'confidentiality'?" "What do you know about HIV infection?" "What do you know about how HIV is transmitted?" "What do you think about using condoms?"
- Who: "Whom have you spoken to about taking an HIV test?"
- Why: "Why" questions must be chosen carefully, because they can be taken to imply judgment or seen as accusatory, which can make a client defensive. The counselor should make an effort to ask "why" questions only of a positive nature; those that can help clients explore the dynamics of their successes, rather than their failures. An example of a positive "why" question is: "That's terrific! Why do you think you were able to use a condom that one time?"

Although it is recommended that counselors use open-ended questions as much as possible, they should recognize those instances when closed questions are appropriate. For example, obtaining a client's consent for an HIV test or partner notification requires that the client provide only a simple "yes" or "no".

Clarifying

There are many opportunities during a counseling session for either party (client or counselor) to be unclear about what has been said. Asking for clarification on unclear points can enhance simple communication (e.g., by asking, "Do you mean...?"), or by supplying facts (i.e., by asserting, "No, HIV infection is not transmitted by eating from the same dishes").

Paraphrasing

Active listening requires reflecting on what the client has said. Paraphrasing—restating the client's words in the counselor's own words—is one technique that helps to achieve this objective.

To paraphrase effectively, the counselor must listen actively; the counselor must determine what is being said and check with the client that the paraphrase is accurate. Paraphrasing in the counseling session is meant to:

- Show that the counselor is paying attention to the client
- Facilitate understanding
- Validate the client's statements
- Encourage the client to explore his/her concerns further

Occasionally paraphrasing can be ineffective, particularly when the counselor:

- Repeats exactly what the client has said
- Uses technical language
- Is judgmental
- Debates with the client
- Fails to gain the client's acceptance of the paraphrase

Reframing

Reframing involves responding to a client's comments and then presenting a positive view of the issue. For example, when a client says, “You can’t feel anything when you wear a condom!” an example of reframing might be, “You're right, condoms can reduce sensation. But, you know, lots of men find that when they use condoms they stay erect longer, and they do not have to worry about unplanned pregnancies, STIs, and HIV.”

Empathy

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

for a counselor to communicate an understanding of a client's world, he/she must get in contact with that world, i.e., understand the client so well that the counselor feels what the client feels. To understand what the client is feeling, the counselor must be attentive to the verbal and non-verbal cues of the client. The counselor needs to reflect on: "What feelings is the client expressing, as well as the experiences and behaviors that underlie these feelings?" "What is most important in what the client is saying to me?"

Reflecting feelings is a way of communicating empathy. Counselors reflect feelings by formulating responses that:

- Demonstrate understanding
- Identify basic feelings being expressed verbally or nonverbally
- Recognize the level of intensity of a client's feelings
- Capture the association of feelings in words
- Confirm the client's feelings are normal

Below are useful examples of reflecting feelings in the context of counseling, particularly when the client is primarily expressing feelings and not giving clues about the association:

- "You feel (feeling word: sad, anxious, relieved) because ..."
- "You seem (feeling word: confused, happy, excited). What's happening to you?"
- "How are you feeling about that?"
- "Let me see if I understood you correctly....You....is that right....?"

Reflecting feelings can sometimes be ineffective if the counselor:

- Paraphrases content without naming a feeling nor prompting the client to verbally express the feeling
- Uses feeling words of a very different intensity from those used by the client
- Uses a cold tone, and/or clinical terms
- Adds judgmental interpretations or content

To ease the process of addressing feelings, counselors should:

- Be aware of their own feelings
- Acknowledge the client's feelings and reality
- Understand that it is not the counselor's job to take feelings away or to fix them
- Articulate and respond to nonverbal messages
- Normalize and validate the client's feelings

Counselors may feel the need to resolve problems and fix feelings. Feelings cannot be "fixed" though they may be alleviated. Most importantly, feelings need to be acknowledged.

Examples of statements that acknowledge a client's feelings are: "This must have been hard to deal with," and "So you believe that he cares for you, but it hurts to think about him having sex with someone else."

Summarizing

Sometimes it is helpful for the counselor to interrupt and summarize what both counselor and client have said. This is very much like paraphrasing in that it helps ensure that each person understands the other correctly. Summarizing also can provide guidance and direction to clients as they try to sort out emotions, deal with practical matters, and make plans. At the end of each session, the counselor should summarize the key points of the discussion and highlight decisions that have been made and need to be acted upon.

Probing

"Probes" are verbal tactics that help clients talk about themselves and define their concerns concretely in terms of specific experiences, behavior, and feelings. Probing also helps to identify themes that may emerge when exploring these elements. Probes can help clients explore their initial concerns, examine issues more fully, and/or explore different goals. They can be used to encourage and prompt clients when the clients fail to take those steps spontaneously.

Probing can take the form of statements, interjections (interruptions), or questions. Probing questions are those that help the client to talk more freely and concretely. Counselors can use statements to help a client discuss or clarify relevant issues. For example, a client may come in looking annoyed and sit down without saying anything. The counselor might then probe using the following statement: “I can see that you are angry. I have some idea of what it’s about, but maybe you could tell me more.” Probing statements such as this example are indirect invitations for clients to elaborate on their experiences, behaviors, or feelings.

Counselors also can add in a word or phrase that helps focus a client’s attention on the discussion. For example, a client may say, “I love my fiancé, but I am hesitating in agreeing to marry him.” The counselor can then probe by using the following remark: “Hesitating in agreeing to marry him…' Could you please elaborate on that?” In this instance, the counselor helps the client say more fully something she was only half saying. Interjection can also be non-verbal such as nodding, provided one uses them intentionally.

Questions in probing should be those that help the client talk more freely and concretely. The following are guidelines on questions:

- Do not ask too many questions. When clients are asked too many questions, they feel judged.
- Ask questions that serve a purpose. Don’t ask random, aimless questions but questions that help clients get somewhere.
- Ask open-ended questions that help clients talk about specific experiences, behaviors and feelings. Closed questions will lead to more questions. Here is an example of an open-ended question “Now that you know your HIV status what are your plans?”
- Questions should keep the focus on the client and his/her interests and not on the theories of the counselor.

- Ask questions that will help the client work through a process of exploration and understanding to become committed to action oriented outcomes.

Challenging (also known as "confronting")

Challenging is a technique used to reflect a contradiction expressed by a client. Contradictions include differences between self-perception and behavior; between verbal and nonverbal messages; or between two different verbal messages. Challenging can also be an invitation to examine behavior that seems to be self-defeating and/or harmful, and to change this behavior. A counselor should help the client identify and challenge his/her blind spots. A challenge should be delivered in a neutral tone.

If the client responds with persistent denial, the counselor must let go. The following is an example of challenging in the context of a counseling session:

- "Based on what you told me, in that you have multiple partners and you do not use condoms with all of them, I am really concerned that you could get HIV. What do you think about your potential risk of acquiring HIV infection?"

Clients can be helped to challenge themselves to:

- Talk about their problems when they are reluctant to do so.
- Clarify problematic situations in terms of specific experiences, behaviors, and feelings when they are being vague.
- Develop new perspectives rather than sticking to distortions.
- Say what they want, review and critique alternative scenarios, develop goals and commit to reasonable agendas instead of wallowing in the past.
- Search for ways of getting what they want even in the face of obstacles.
- Spell out specific plans instead of being vague in their approach to change.

- Continue to implement these plans when they are tempted to give up.

What needs to be challenged is:

- Failure to own problems.
- Failure to define problems in solvable terms.
- Faulty interpretations of critical experiences, behaviors, and feelings.
- Avoidance, distortions, and game playing.
- Failure to identify or understand consequences or behavior.
- A hesitancy or unwillingness to act on new perspectives.

Specific goals of challenging:

- Challenge clients to participate fully in the helping process.
- Help clients become aware of their blind spots in thinking and acting and help them develop new perspectives.
- Challenging clients to own their problems and unused potential.
- Help clients state problems in solvable terms.
- Challenge clients' games, distortions, and excuses.
- Invite clients to explore the short and long term consequences of their behavior.
- Help clients move beyond discussion and resistance to action.

Questions for Counselors to Evaluate their Interpersonal Skills:

- When a client asks you a question that is not clear, do you ask the person to explain what he/she means?
- Do you ever ask the other person to explain how he/she feels about the point you are trying to make?

- Is it difficult for you to talk with people?
- Do you tend to do more talking than the other person?
- Do you refrain from saying things you know will hurt others or make matters worse?
- Do you find it difficult to think clearly when you are angry with someone?
- Do you tend to change the subject when your feelings enter into a discussion?
- Do you let the other person finish talking before reacting to what he/she says?
- In conversing with others, do you find yourself not paying attention?
- Do you ever try to interpret what someone is saying?
- Do you pretend you are listening to others when actually you are not?
- Can you tell the difference between what a person says and what he/she may feel?
- When speaking, are you aware of how others are reacting to what you are saying?

Chapter 4

Pre-Test Counseling

Pre-Test Counseling

In every counseling session, there are various essential elements that must always be ensured. Below is a list of the fundamental issues of VCT:

- Each individual should be provided with information that allows him/her to decide for him/herself whether to be tested (informed decision with informed consent).
- The HIV testing procedure should be organized in a way that maximizes confidentiality.
- HIV testing should be linked with information and recommendations regarding HIV prevention, care, and support.
- Adequate counseling should be provided to all individuals seeking an HIV test.
- Disclosure of HIV status should be discussed with all clients. If a client is found to be HIV-positive, he/she would be encouraged to disclose the result to sex partner(s).
- Appropriate referral should be offered as required.

Pre-test counseling occurs before a client's blood is tested for HIV and is done:

- To review a client's risk of infection.
- To explain the test and clarify its meaning.
- To explain the limitations of test results and to caution the client about potential misuse of results (i.e., to understand that a negative result remains negative only as long as no new exposure to risk occurs, providing the client is not currently in the window period).
- To help the client think about possible reactions to the test result and whom to inform.

- To help the client understand why the test is needed and to make a decision about the test.

Points to be covered in pre-test counseling

- Establish a good relationship with your client. Introduce yourself and clarify your role.
- Emphasize confidentiality.
- Obtain the client's particulars as per local protocol: code number, code name, age, sex, occupation, education, marital status (but with no defining information).
- Establish what prompted the client to come for VCT.
- Assess the client's knowledge of HIV/AIDS, correct misconceptions/ misunderstandings and provide information.
- Conduct personalized risk assessment.
- Assess the client's understanding of what the test entails, its implications and the meaning of a positive or negative result and the window period to the clients, their family and/or significant others.
- Explain how the test is done and how long it will take for results to be available. Inform the client of where the testing is done. Give details of how to go through the "system".
- Provide education on safer sex practices (including a condom demonstration when appropriate) and healthy lifestyle practices
- Develop a personalized risk reduction plan; discuss with the client what might be required in the area of behavior change whether the result will be positive or negative.
- Assess client ability to cope: who they will tell or talk to about their results and where they will get support. Explore areas of strength, e.g., faith and/or other support systems (supportive husband/wife, relatives, or workmates).

- Provide psychological emotional support and referrals as appropriate.
- Provide an opportunity for the client to ask questions.
- If the client decides to test, obtain informed consent.
- Arrange a date and time for post-test counseling or follow-up.

Risk Assessment

An individual's lifestyle and behavior are major controlling factors in their likelihood to become infected with HIV/AIDS. In the context of HIV/AIDS, sexual behavior is probably the most important behavior to consider. Reducing HIV transmission and helping HIV-positive clients stay in good health are essential components of the counseling process. The counselor's job is to help clients choose safe and healthy behavior patterns, by developing a risk reduction plan. To assess a client's personal risk, the counselor should explore the following areas:

- Current and past sexual behavior (number of partners, type of partners, frequency of partner change, unprotected vaginal and/or anal intercourse).
- Current and past sexual behavior on the part of the client's sexual partner(s), if known.
- Current and past drug and/or alcohol abuse by the client and the client's partner(s), if known.
- Client's history of blood transfusion (i.e., date and location, and whether the blood was screened for HIV).
- Current and past exposure to non-sterile invasive procedures (injections, scarring, circumcision, tattooing, piercing).

Counselors can use probing, repeating, paraphrasing and reframing to obtain accurate information. Open-ended questions (e.g., "What can you tell me about your current sexual relationships?") are generally more productive than closed "yes or no" questions (e.g., "Are you currently in a sexual relationship?")

for obtaining detailed information and showing interest without judgment. Based on the information provided, counselors can help clients identify and recognize the connection between the modes of transmission discussed earlier and their own particular behavior or practices that may put them at risk for acquiring or transmitting HIV.

Individualized Risk Reduction

Rather than telling clients how to change their risky behavior, counselors can assist the client in developing a specific risk reduction plan.

Steps for developing an individualized risk reduction plan:

- The counselor asks the client to propose some ideas about how to reduce his/her risk of HIV exposure.
- The counselor may initiate a discussion of risk reduction by listing several alternative risk reduction strategies for the client to consider (e.g., use condoms, have fewer or less risky partners, have safer sex, stop injecting drugs).
- For each risk reduction behavior, the counselor assesses internal and external obstacles to change, perceived efficacy in enacting the new behavior, readiness to change, and availability of resources to support change.
- In supporting a client in enacting his/her personalized risk reduction plan, the counselor acknowledges and supports the client's strengths (e.g., social support, self-efficacy, previous success in changing behavior) and assists in problem solving in areas of concern or expected difficulty.
- If condom use is part of the risk reduction plan, the counselor asks the client to tell what he/she knows about condoms and invites the client to practice putting a condom on a penis model before the counselor conducts the condom demonstration. If the client does not mention condoms, the counselor may introduce the subject, whether or not the client is planning to use them.

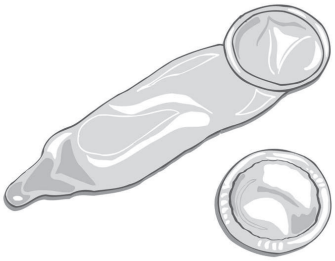
- The counselor obtains a commitment from the client to try to implement specific behavioral changes before the next counseling session.

The individualized risk reduction plan can be useful in providing several goals, some of which may be easy to attain, while others may be more difficult. It also can be useful to divide the new behavior into steps and encourage the client to take these steps one at a time. Some clients might find it useful for the plan to be written out to take home.

Demonstrating Condom Use

Condom demonstrations to clients are an integral part of pre-test and, sometimes, post-test counseling. The use of condoms is an integral part of individualized risk reduction. All counselors should provide condom demonstrations to VCT clients as appropriate and with the clients' permission. Condoms should be available at each VCT site. Information on where to purchase condoms can also be given to clients as appropriate.

The male condom



The male condom is the best-known and most commonly used means of protection against HIV transmission. It is made of latex and looks like a long balloon that fits over the penis. The condom is often lubricated and needs to be used properly in order to be effective. Condoms should be stored in a cool, dry place and should not be subjected to changes in temperature (i.e., should not be stored in one's pocket for long periods of time). The decision about whether to use a condom usually rests with the man; many women have a great deal of difficulty getting their sexual partners to agree to it. With the aid of a diagram or penis model, counselors can use the following text to demonstrate male condom use:

1. Make sure the expiry date has not passed.
2. Ensure the packaging is still air tight.
3. Push the condom to one end of the package and open the packaging, taking care not to rip the condom.
4. Pinch the end of the condom and place it on the erect penis.
5. Still pinching the end, unroll the condom right to the base of the penis.
6. If you want to use a lubricant, choose one that is water-based. Oil-based lubricants cause condoms to tear.
7. After ejaculation, hold the condom and withdraw the penis before it becomes soft. Never reuse a condom.
8. Wrap and dispose of the condom in a bin, not the toilet.

The female condom

The female condom is a sheath made of polyurethane, which is stronger and more supple than the latex used in male condoms. At the closed end of the sheath is a ring used for putting the condom in place. At the open end of the condom is an outer ring. This outer ring lies outside the vagina and covers the vaginal opening and the base of the man's penis. The woman should guide her partner to make penetration easier. The female condom is pre-lubricated and should only be used once.

1. The condom has two rings: the inner ring, which allows the condom to be inserted into the vagina, and the outer ring, which is larger and covers the exterior of the vagina.
2. Squeeze the inner ring between your thumb and forefinger.
3. Insert the folded ring into the vagina and push it in as far as it will go.

4. The inner ring should stay in position, and the outer ring should cover the opening of the vagina.
5. After ejaculation, remove the condom before getting up. Pinch and turn the outer ring then pull the condom out gently. Dispose of the condom in a bin, not the toilet.

Explaining the meaning of test results

Clients considering an HIV test must be provided with the information they need to make an informed decision. The counselor should initiate the conversation by asking the client what he/she knows about the HIV test. The counselor can then provide information about HIV testing as needed, describe the testing procedures used at the center, state that the testing is anonymous, and correct any misconceptions.

Given that clients often have concerns about the accuracy of the test and pose specific questions about the laboratory procedures used, it is important that counselors be knowledgeable about the testing procedures. The counselor should inform the client about how long it will be before the test results are available. If the test requires a fee, the client needs to be informed about the cost and methods of payment.

Obtaining informed consent for testing

When giving informed consent, clients must evaluate the information they receive without any pressure from the counselor. If the counselor has provided all of the necessary information and the client decides to take the test, the counselor makes arrangements for the client's blood to be drawn. It is crucial that the client is reassured that the test results will be held in the strictest confidence. This is also a good time to set up an appointment to return for the results (if it is not one of the tests with same-day results). See Appendix A for a sample of an Informed Consent Form.

Chapter 5

HIV Testing

HIV Testing

Selection of HIV Testing Strategies

HIV testing strategies vary from one country to another depending on the estimated prevalence of HIV infection and the technologies available. Today there are numerous high-quality HIV testing kits on the market. It is the responsibility of the MOHP, National AIDS Programs and the Central Laboratory to formulate testing strategies for Egypt. The MOHP has developed a list of HIV Rapid Test Kits approved for use in Egypt. Considerations for the choice of HIV testing protocols include:

- Scientific validity of the tests.
- Existing laboratory infrastructure.
- Presence and capability of reference laboratories for quality control purposes.
- Volume of HIV testing required (i.e., number of people to be tested).
- Prevalence rates.
- Client preferences.
- Impact of protocol on provision of services (e.g., same-day results vs. return appointment).
- Costs of tests vs. available funds.

The selection of testing strategies takes into account the scientific validity of the test (accuracy). The two measures that are used to measure this are sensitivity and specificity.

- Sensitivity is the probability that a test will be positive when infection is present (i.e., the sensitivity of a test is the percentage of those identified by the test as having the infection who actually have it). For example, if a test is 99 percent sensitive, then 99 out of 100 HIV-positive people will correctly test positive, and one person will falsely test negative.

- Specificity is the probability that a test will be negative when infection is not present (i.e., the specificity of a test is the percentage of those identified by the test as not having the infection who are actually free of infection). In other words, if a test is 99 percent specific, then 99 out of 100 people who are not infected will correctly test negative, and one person will falsely test positive.

The first test should have a higher sensitivity (greater than 99 percent) and confirmatory tests should have a higher specificity (greater than 99 percent). The sensitivity and specificity of the latest generation of rapid tests are similar to those of an ELISA. As the sensitivity of a test increases, the proportion of false-negatives decreases. As the specificity of a test increases, the proportion of false-positives decreases.

HIV Testing Protocols

Diagnosis of HIV infection usually is made on the basis of detection of antibodies to the virus. An antibody test is rarely 100 percent sensitive (i.e., correctly able to categorize an infected person as positive) and 100 percent specific (i.e., correctly able to categorize a non-infected person as negative). The United Nations Program on HIV/AIDS (UNAIDS), WHO, and other international experts jointly recommend that all positive test results be confirmed by retesting, preferably by a different test method.

Voluntary counseling and testing centers will have defined testing protocols, or algorithms, to guide individuals administering the tests. The protocols depend on national testing guidelines, HIV prevalence, the purpose of the testing, and the number of different HIV tests available in the particular setting.

Types of HIV Tests

There are two main types of HIV tests:

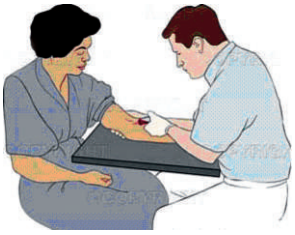
- Antibody tests (e.g., ELISA, simple/rapid, saliva and urine, and Western blot).

- Virologic tests (e.g., HIV antigen test, polymerase chain reaction [PCR] test, and viral culture).

Antibody tests

HIV antibody tests look for antibodies against HIV; they do not detect the virus itself. When HIV enters the body, it infects white blood cells known as CD4 cells. The infected person's immune system responds by producing antibodies to fight off the new HIV infection. The presence of the antibodies is used to determine the presence of HIV infection.

The most commonly used antibody tests are the Enzyme-Linked Immunosorbent Assay (ELISA) and the rapid HIV test. The less commonly used Western blot antibody test is used mainly in industrialized countries to confirm a prior test. The Western blot is better than other tests at identifying when a person is not infected, but it is more expensive than other tests.

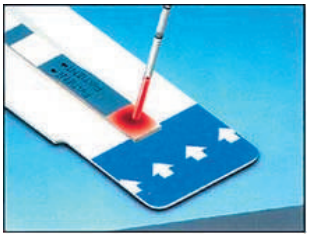


In Egypt, the MOHP central laboratories use ELISA to conduct preliminary HIV testing, with the Western Blot used for confirmatory testing (see Figure 7). Rapid tests are also available in various sites in Egypt.

In addition, the Radio-Immunoprecipitation Assay (RIPA), a confirmatory antibody test, is used when antibody levels are very low or difficult to detect, or when results of the Western blot are uncertain. RIPA is an expensive test and requires time and expertise to perform.

Rapid HIV testing

Voluntary counseling and testing sites that do not see a large number of clients per day, or that are far away from the closest laboratory, often use rapid test kits to test for HIV.



- Some rapid HIV antibody detecting tests produce results in just a few minutes. Of these tests some do not require a blood sample from the client, but use a "finger prick" method instead.
- Rapid tests are recommended in remote areas or those with little or no laboratory infrastructure and in small facilities that perform less than 100 tests per day.
- Rapid tests are faster and generally easier to perform.
- Rapid tests offer same day results, substantially reducing the proportion of clients that do not return for their results.
- If a rapid test is used and is positive, then follow the test algorithm (figure 7) starting with the 1st ELISA screening.

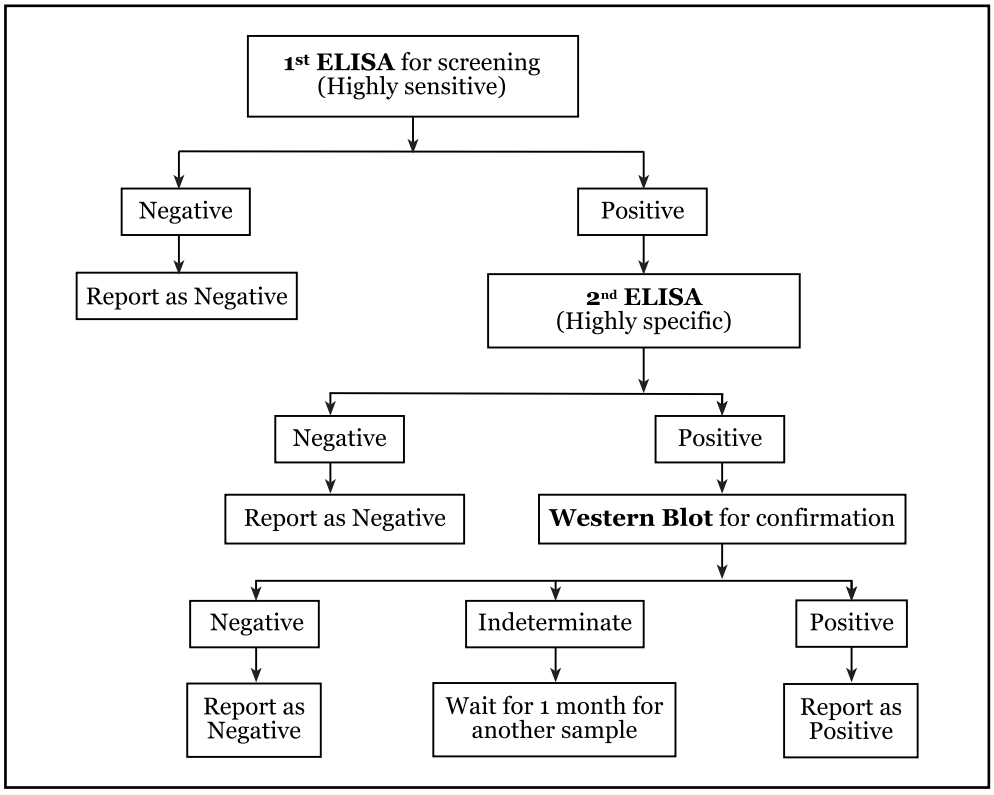


Figure 7: Interpreting the Test Algorithm

For quality control purposes, five to ten percent of all samples must be sent out for external quality assurance testing. This will be either a venous sample or a sample collected using a filter-paper method. For instance, in Egypt, one of every ten positive samples and one of every twenty negative samples must be sent to the Central Laboratory for quality assurance. The Central Laboratory operates as the official External Quality Assurance agency for all HIV testing in Egypt.

Saliva and urine testing

HIV tests based on samples of urine and oral fluid offer an alternative to blood-based tests. However, testing urine for HIV is not as sensitive or specific as testing blood. Available urine tests include the ELISA and the Western blot, which can confirm the ELISA results.

Saliva-based tests collect oral fluids, which are tested for the presence of HIV antibodies. It is important to note that even though HIV antibodies can be detected in saliva, HIV cannot be transmitted through saliva. A trained specialist usually collects the sample between the lower cheek and the gum. Testing a specimen for HIV antibodies is accurate, but testing blood is even more accurate. However, when both tests are available, clients may be allowed to choose.

The "window period"

In some cases, HIV tests may come back as negative even thought the person is infected with HIV. This can happen during the "window period"; the time between initial infection with HIV and when the body builds a measurable antibody response to it. During this window period, HIV is not detected by most HIV tests even though it is replicating in the blood and lymph nodes. The virus can be detected during this phase only by laboratory tests used to identify the virus itself. The window period can last from one to three months. Therefore, if a person tests negative to HIV by antibody tests, one possible

explanation is that they are still in the window period, in which their immune system has not yet begun making antibodies to the virus. A person in the window period will only test positive for HIV if a virologic test (described below) is used.

Virologic tests

The antibody tests discussed above are the most commonly used in VCT settings, however, under special circumstances (e.g., in a recently infected individual, during the "window period," or in the case of a child born to an HIV-positive mother), more direct diagnostic methods may be used. Unlike antibody tests that detect antibodies the immune system has created in response to the virus, the virologic tests determine HIV infection by detecting the virus itself. There are three virologic (direct) tests:

- Viral antigen detection test (also known as the P24 antigen test).
- Nucleic acid-based tests: specialized tests looking for genetic information on HIV (using “polymerase chain reaction,” or PCR).
- Virus culture, which isolates the virus.

Virologic tests are rarely used to diagnose HIV in developing countries, since they require sophisticated laboratories. However, they may be used to monitor progress of infection or response to therapy (i.e., by measuring viral load) and they are used in Egypt.

HIV tests and children

Only virologic tests, such as polymerase chain reaction (PCR), viral culture, and P24 antigen testing, will prove whether an infant is infected, since maternal antibodies may take up to 15 months to clear. Clinical evaluation with repeated testing over at least the first two years of life has been the primary means of establishing a diagnosis in these children.

Interpretation of HIV Test Results

Explaining test results

A negative test result means that HIV antibodies were not detected (either because the person is not infected or because the person is still in the window period). The client must understand that a negative result does not mean that the person is uninfected or immune to HIV infection.

An HIV-negative person is still vulnerable to HIV infection if he/she engages in risky behavior. A person who tests negative but has practiced unsafe behaviors during the window period may be (or become) infected with HIV and infectious to others.

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

An **indeterminate test** result means that the presence or absence of HIV antibodies could not be confirmed. This can mean one of three possibilities:

- The person may be in the process of sero-converting.
- The person may have had an earlier infection or immunization that is cross-reacting with the HIV antibody test (cross-reactivity does not necessarily mean HIV is present).
- The person may have a prior medical condition that is affecting the test (e.g., arthritis or autoimmune problems).

The information in the figure 8 can be used to explain the meaning of the HIV test results.

Negative:

A negative test result indicates that no antibodies to HIV were detected in your blood. This result means one of two things:

1. You may not be infected with HIV.
2. You may be infected with HIV, but your body has not had time to produce antibodies to the virus. In this case, you are in the window period.

Positive:

A positive test result indicates that antibodies to HIV were detected in your blood. This indicates you have been infected with HIV; it does not necessarily mean you have AIDS.

Indeterminate:

An indeterminate test result may mean one of the following:

1. You may be infected with HIV and in the process of developing antibodies to it (acute sero-conversion).
2. You have antibodies in your blood that are similar to antibodies to HIV. These antibodies are reacting to the HIV test.

Individuals with indeterminate results should undergo a second test one month after the first test. If results are negative or remain indeterminate and the individual has not put him/herself at risk since taking the first test, he/she can be reasonably certain of not being infected with HIV.

Figure 8: Explaining the Meaning of Test Results

False positive

HIV tests have been developed to be especially sensitive; consequently, a positive result may be obtained even when there are no HIV antibodies in the blood. This result is known as a "false positive", and, because of it, all positive results must be confirmed by another test method. Confirmatory tests usually rule out false positive results. False positives have many causes including technical errors, serologic cross-reactivity and repeated freezing and melting of specimens. There is also a risk of false-positive results occurring in persons with:

- Rheumatoid arthritis
- Multiple sclerosis
- Systemic lupus erythematosus
- Type I diabetes mellitus
- Addison's disease
- Ankylosing spondylitis
- Chronic hepatitis
- Cancer (particularly lympho-proliferative malignancies)
- Severe kidney disease
- And in persons who have had a:
    - Flu vaccine within the past 30 days
    - Gamma globulin injection
    - Recent transfusion or organ transplant

False negative

A false negative occurs in an infected person when the blood tested gives a negative result for HIV antibodies, even though it should have showed positive. The likelihood of a false negative test result must be discussed with clients if their history suggests they have engaged in behavior likely to put them at risk for HIV infection.

Repeated testing over time may be necessary before the client can be reassured that he/she is not infected with HIV. The most frequent reason for a false negative test result is that the individual is newly infected and is not yet producing HIV antibodies. However, it is important to remember that someone who has correctly tested negative because he/she is not infected with HIV can nevertheless become infected at any time afterward.

Confidentiality in HIV Testing

Sometimes a client may request an HIV test because of his/her self-perceived risk or other reasons, and other times, a health care provider recommends a test based on a patient's behavioral history and/or clinical findings, such as STIs or opportunistic infections.

HIV testing and counseling should always be voluntary and confidential. All information about the individual and his/her sexual partners must be kept strictly confidential. Confidentiality will help win a client's trust and avoid stigmatization and discrimination. Careful record management is a pre-requisite for confidentiality.

There are three general methods of labeling blood samples to ensure confidentiality:

- Linked testing
- Linked anonymous testing
- Unlinked anonymous testing

In linked testing, the blood sample sent for testing has an identifier on it, such as a name or a clinic number that links the sample to the individual client. To ensure maximum confidentiality for clients, samples sent for HIV testing should not be identified with a name, but with some other identifier, so that laboratory technicians and other people with access to laboratory

records will not be able to identify the client. Sometimes HIV test request forms will have sequential numbers printed on them whereby the laboratory gets copies of the request with a number only and the clinic retains copies with the number and client information.

In linked anonymous testing, no names or other identifiers of the client are recorded. The client receives a unique number, in no way linked to any medical record that matches the number on the blood sample sent to the laboratory. The result from the laboratory for the specific number is reported back to the clinic or counseling site. To learn the result, the client must come to the clinic or counseling site and present the correct number. No record is kept of clients who provided blood for samples, and there is no way to find the client if he/she does not return for results. This is the type of testing being conducted in all Egyptian VCT sites.

Unlinked anonymous testing is often performed on blood samples obtained for reasons other than diagnosing HIV (e.g., syphilis serology in antenatal clinics or blood donations). In this procedure, all identifiers are removed from the blood sample, and the sample is tested for HIV antibodies. Unlinked anonymous testing means test results cannot be traced back to the clients who provided the blood samples and no record is kept of those clients. Unlinked anonymous screening is sometimes used in circumstances to monitor trends in HIV infection in different geographic areas and populations and to further understand the natural history of HIV infection.

Chapter 6

Post-Test Counseling

Post-Test Counseling

One of the aims of post-test counseling is to help clients understand and accept their test results. In addition, the post-test counseling session offers a chance for the counselor to assist the client in making choices in response to their test results. The messages will be different for those who test positive and those who test negative.

Points to be Covered in Post-Test Counseling

- Prepare yourself and the client to receive the result.
- Give the result.
- Check what the client understands by the result.
- If negative: suggest a re-test one month from the client's last exposure, if appropriate. Reinforce strategies for prevention of transmission and safer sex.
- If positive:
  - ◇ Accommodate the client's reaction to the news.
  - ◇ Check their knowledge of HIV and AIDS.
  - ◇ Give information according to their ability to understand.
  - ◇ Identify immediate concerns: who the client might tell about the result; when and how the client might tell others (you may role-play with him/her); how the client plans to spend the next few hours and days.
  - ◇ Identify what difficulties the client may foresee and how he/she might deal with them.
  - ◇ Help them see that there are things they can do about their worries, so that they feel they can still control their lives.
  - ◇ Help the client identify who else he/she might turn to for support.
  - ◇ Encourage the client to ask questions and be sure to address misconceptions.

- ◇ Discuss risk reduction strategies including their responsibility to protect others. Repeat the information about “safer sex”. He/she must not decide that “safer sex” does not matter now that he/she is infected.
- ◇ Assure the client that reacting with shock, anger or disbelief is a common response to a positive result.
- ◇ Discuss medical follow-up care and the benefit of prompt identification and treatment of symptoms.
- ◇ Give information and, where appropriate, referral to care and support organizations.
- ◇ Check that all is understood; ask him/her to repeat what you have discussed.
- ◇ Always offer a follow-up appointment.

Questions and Answers about Post-Test Counseling

Question: *Many clients find it difficult to tell their spouse or sex-partner about a positive result. How can you help them?*

Answer: Ask them what they think their partner’s reaction will be (e.g., sadness, anger, silence) and how have they coped when their partner has reacted like this in the past? The client may find it helpful to role-play with the counselor or how to tell the partner. The counselor can offer to be present when the client tells the partner.

Question: *What can you do if a client refuses to tell their partner?*

Answer: Ask questions that challenge the client's view that he/she does not need to tell his/her partner. For example, "How will you feel if your partner becomes infected with HIV because you have not taken precautions"? How will you feel living with this secret?" The AIDS epidemic raises many such difficult ethical issues which require ongoing discussion, and which have no clear answer. Such situations can also be addressed with assistance from the site supervisor.

Question: *Under what circumstances may a counselor have to breach a client's right to confidentiality?*

Answer: The following are the only circumstances under which confidentiality may be breached; they will only apply in rare cases, when all other avenues have been explored and must be made known to the individual client or couple prior to commencement of counseling:

- Where an individual is at risk of harming him/herself (e.g., self destructive behavior, suicidal tendencies, etc.).
- Where an individual is at risk of harming others (e.g., violent behavior, knowingly planning to infect or expose another individual to HIV, etc.).
- Where an individual is unable to make competent decisions for him or herself.

In these circumstances the client must be informed of the counselors "duty of care" and intention to notify another party, e.g., psychiatric services or a potential partner at risk.

Possible Client Reactions

Clients react in a variety of ways to a positive test result, from resignation to severe shock and disbelief. Some clients assume they will become ill immediately and die. It is important to remind them of the difference between HIV and AIDS, and to point out that, with HIV, it is possible to remain healthy for a long time. Counselors should ask clients what they are planning to do when they leave the session and, if necessary, remind them of the plan they made during the pre-test session for what they would do if their result was positive. Counselors will need to assess the client's social support system and his/her plans for partner notification. Although clients who receive a positive test result are not likely to be concerned about safer sex during the

first post-test counseling session, it is important to remind them of their risk reduction plan and that it is necessary to protect their partners from infection and themselves from re-infection.

There is also a wide range of potential client responses to a negative test result. Counselors must not assume that clients will react with relief and happiness to such a result. Clients who receive negative results often tell counselors they will stay safe by no longer having sex. While acknowledging the client's intention not to have sex, the counselor must be sure that the client has sufficient skills and a plan to protect him/herself in the event that he/she does have sex. Counselors also should ask clients who test negative whether they intend to tell their partner(s) they were tested, and they should engage clients in planning how to discuss risk reduction with their partner(s).

At this stage, the counselor should ask specific questions to ascertain the client's ability to cope, assess whether he/she has a history of threatening suicide or harming others, and learn whether the client has had any other unfortunate experiences recently. The counselor also must determine whether the client has a specific plan to harm him/herself or others, and whether he/she has the means to pursue such a plan. If the answer to any of these questions is yes, the counselor must act by contacting a trained clinician to evaluate the client and assess possible interventions. All clients should be informed of and/or referred to community resources if they need services that are not available at the center.

Possible strategies when clients are unable to cope with their emotional reactions

- Identify, explore, and validate the client's ability to cope with past crises and the techniques he/she used to do so. It is reassuring to clients to be reminded that they have coped with and solved personal problems in the past. Discussion of past crises may provide counselors with clues in assisting clients to cope with the present crisis.

- Encourage the client to make a specific short-term plan for coping. The counselor should elicit a personal commitment from the client to follow this plan and report back to the counselor. For example, the counselor might ask the client what he/she is planning to do after leaving the session and arrange a return appointment to discuss it.
- If appropriate, engage the client's family members and friends (with the client's permission) to ensure that the plan is enacted and the client returns for follow-up care.
- Encourage the client to express his/her feelings about the current situation during the counseling session, and then redirect the client's attention to taking action and solving problems.
- Encourage the client to take advantage of existing social supports.
- Provide the client with appropriate referrals to community resources.

If the client does not respond to these techniques or refuses to engage with the counselor, the counselor should request assistance from a more senior counselor or psychologist.

Post-Test Counseling Messages for the HIV-Negative Client

- Discuss the challenges of remaining negative.
- Pretend "everybody is positive except you" – by keeping this in mind the client should be encouraged to see prevention as the ideal scenario and protect themselves in every potential infectious encounter.
- Reinforce the ABC message (A = abstinence, B = be faithful to one uninfected partner and C = correct condom use consistently).
- Negotiate with partner to go for VCT.
- Safe sex negotiation skills, including encouraging them to use condoms and have fewer or less risky partners.
- Importance of being re-tested if additional risk exposure occurs or if in the window period.

- Safer sex options:
  - ◇ Enjoy the sensation of another person (holding, caressing, and hugging).
  - ◇ Spend more time getting to know your partner(s). Reduce your number of partners.
  - ◇ Talk about sex first; this clears the air and reduces tension, so that both of you will have a better time.
- Vaginal and anal sex is the primary means of transmitting HIV, but it can also be transmitted by oral sex.
- Limit or reduce alcohol and/or other drug intake, since it may impair judgment needed to make decisions about protection and may also weaken your immune system.
- Promote abstinence from injecting drug use.

Post-Test Counseling Messages for the HIV-Positive Client

To stay healthy, we recommend that you:

- Refer to follow-up care and support.
- Take care of your health, see a doctor immediately even for minor illnesses.
- Maintain your weight by eating a balanced diet, preventing diarrheal diseases, exercising regularly, and resting.
- Talk to family and/or friends whom you can trust.
- Avoid alcohol or smoking; they may weaken your immune system.
- Tell your partner(s) you have tested positive.
- Practice safer sex with all partners or abstain from intercourse.
- Protect your unborn child: If you or your partner is considering pregnancy, or are currently pregnant, discuss options with your counselor and health care provider. If adequate precautions are taken, many HIV positive individuals may still have healthy babies.

- Do not donate blood, plasma, or serum.
- Do not donate organs (eyes, kidneys, etc.) for transplant.

Post-Test Counseling Messages for the Client with an Indeterminate Test

- Practice safer sex and abstain from any other risk behavior.
- Tell your partner you have tested indeterminate and that you are awaiting another test.

Chapter 7

Care and Support for People Living with HIV/AIDS

Care and Support for People Living with HIV/AIDS

Living Positively

Positive living with HIV is a lifestyle in which one tries to delay the onset of AIDS symptoms or avoid contracting HIV in the first place. This implies discarding all practices that may expose one to HIV if one is not yet infected. For those with HIV, one's lifestyle is modified to deter progression to AIDS.

It should be stressed that all people, whether HIV infected or negative, can adopt a positive lifestyle. For those that test negative, they should continue to maintain their negative status. This should be done by refraining from all behavior that places them at risk of contracting HIV, including abstaining from risky behavior such as indulging in unprotected sex or the use of unsterilized instruments for traditional, cosmetic or medical purposes.

For those already infected, positive living assists in boosting a compromised immune system by way of good nutrition and the protection of one's body from opportunistic infections.

The principles of positive living

Be informed: What you don't know can hurt you when it comes to HIV/AIDS. Learn everything you can about HIV infection to reduce unnecessary worries and problems.

Acceptance: This implies a positive realization that one has a life threatening infection; but in no way should it result in indifference and resignation, blame or guilt.

Work: As long as you are capable of working you should continue. Stopping work or your daily routine may be damaging to your health. Boredom, depression and loss of self worth may quickly fill the gap. Consequently, your

health may be adversely affected, making you more vulnerable for HIV to impair your immune system further.

Stress: Avoiding stress is important but do not deny yourself worry. Deal with your worries and fears to the best of your abilities. Worry and feel depressed if necessary but quickly regain your senses. Denial itself may be a source of depression.

Nutrition: Continue to eat regular, traditional meals. If one does not have adequate resources, foods that contain carbohydrates, proteins and all the necessary nutrients can be found in ordinary, less expensive foodstuffs. (See the section on nutritional support for people living with HIV/AIDS for more information.)

Prevent: Prevent infections such as TB, STIs and pneumonia. Adopt a good standard of hygiene.

Stop or Reduce: The consumption of alcohol, cigarettes and other drugs must be reduced or stopped. These impair immunity and may quicken one's progression to AIDS.

Exercise: If possible, but avoid straining yourself. Get enough rest. Think carefully about your sexual life including childbearing. Abstain from sex or practice safe sex.

Understand: Your health, disposition, and what other people feel about interacting with HIV positive people. This will reduce unnecessary mental stress on your part and facilitate your interaction with other people.

Laugh and be cheerful whenever you can.

Why Should You Care?

Caring for people with AIDS is very important as it helps create a feeling of acceptance. Unconditional care helps a person living with HIV/AIDS develop a sense of living positively. Care can alleviate the problems the person is going

through and make him or her feel wanted. This in effect may provide the client with a motivation to live and may deter notions of hopelessness or ideas about committing suicide. If someone is properly cared for, negative ideas, such as spreading the infection to others so that others are punished, may be reduced.

Caring for Someone with AIDS

Medically

In spite of recent advances in the treatment of HIV/AIDS, there is no cure. Unlike other diseases, it is not easy to predict when death will occur. A patient may die as a consequence of his or her first HIV manifestation or may develop a life-threatening opportunistic infection and recover if appropriate, timely treatment is given.

Most patients will experience an increasing frequency of health problems and finally reach a stage of severe immunosuppression over a period of several years. As the disease progresses, the need for symptomatic relief will become more important than curative treatment. For information on the medical treatment of HIV/AIDS patients in Egypt, please refer to the *National HIV/AIDS Clinical Care Guidelines* .

Palliative care is the active total care of patients and their families and friends when a patient's disease is no longer responsive to curative treatment and life expectancy is relatively short. The goals of palliative care is to provide care and support that makes life comfortable for patients throughout all phases of the disease so they can live as fully and comfortable as possible.

The underlying principles of palliative care include:

- Management of symptoms
- Psychosocial support

- Teamwork and partnerships, particularly in reducing stigma
- Appropriate ethical considerations
- Sustaining hope with realistic goals

Physically

Appropriate precautions should always be taken when providing care and support for people living with HIV/AIDS.

- Cover cuts or sores with waterproof dressings.
- Use bleach to disinfect spilled blood, stool, urine or vomit; wipe it up with paper and dispose of it down the toilet or latrine. If the patient is not too ill he/she can do this for her/himself.
- Cover your hands with surgical gloves or plastic bags if you are handling body fluids. Wash your hands immediately if there is accidental contact with body fluids..
- Do not share toothbrushes or razors
- Protect the person from infection by giving them freshly prepared food, boiling their drinking water if the water is not treated and keeping their room clean.
- Avoid things that make the immune system less effective and do all you can to strengthen it.

Some issues to consider

- *Severe weight loss:* May be directly due to the HIV infection but also may be due to inadequate nutrition, anemia, chronic diarrhea and psychological stress. Nutritional assistance, rehydration and psychological support may be required.
- *Fever:* This may be an indicator of an opportunistic infection and should be taken seriously. Investigate and treat accordingly.
- *Respiratory distress*: Often caused by pneumonia and TB; it is among the most common complication of HIV/AIDS. Prevent or investigate and treat accordingly.

Psychologically

To care for a person with HIV demands great understanding of the patient's potentially unstable frame of mind. Problems can occur if the client has not been taught about the positive living lifestyle. Too much caution concerning the client's "do's" and "don'ts" might make him or her feel oppressed, and too much care might emphasize the patient's fear of being an invalid. People with AIDS may at times try to perform tasks that are harmful to their health. If this type of situation occurs, try to gently persuade the patient to see the reality of their state of mind and refocus their energy. At times patients may develop attitudes which make them complain and find fault with everything accorded them. It will do more harm if the person caring for them also argues with them. Rather, withdraw slightly to allow the patient to calm down.

Helpful Hints for Promoting Care and Support Options

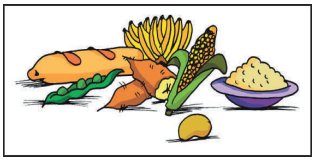
- VCT services are most effective when they have "value added services" such as access or linkages to care and support options, skills training, or income generating mechanisms. We must be able to offer individuals a package – especially the most socio-economically disadvantaged. There must be a perceived benefit in knowing one's status. Without this package, knowing one's status may simply be perceived as a death sentence.
- Positive living strategies are important.
- Explore the use of antiretroviral therapy (ART) by HIV positive people (where available, affordable and feasible). The Egyptian MOHP/NAP provides assistance to HIV-positive individuals in obtaining ART.
- Traditional medicines/herbs may play a role in boosting the immune system although there is no evidence to suggest they cure AIDS.
- Encourage prayer – if this is desirable and requested by the client. The use of prayer is a strategy that may provide comfort and hope for some people. Be aware that there is no evidence that prayer can

eliminate the virus from one's body. Once a person is infected with HIV, they remain infected for life. However, it is true, that the viral load (amount of virus in the body) can be significantly reduced to undetectable levels through the use of ART.

- For HIV positive people with financial means and access, CD4 cells counts and viral load tests (where available) are encouraged as a means of monitoring their well being and planning for the future.
- Encourage the involvement of family and/or friends where possible.
- Encourage the individual to develop contact with other HIV positive people (as part of a network, support group or on an individual basis).
- Explore the issue of disclosure with the client and where appropriate, assist the client in developing ways and means of disclosing his/her status to the relevant party or parties. The individual must take into account the impact of the disclosure and consider who will provide unconditional support for them if their status is revealed.
- Encourage the client to document and/or share his/her experience in a supportive environment, e.g., write down their story, tell their story in a support group, or be a positive speaker with groups of health professionals.
- Assist the client in exploring creative ways of remaining self-sufficient. Income-generating activities are important. This can be done as an individual or as part of a team or group.
- Provide clients with referrals to services that can offer medical prevention and treatment for opportunistic infections such as TB or pneumonic cystitis pneumonia (PCP).
- Encourage clients to seek early treatment if they become unwell. The development of an STI should be avoided, and if suspected, early treatment should be sought.

Nutritional Support for People Living with HIV/AIDS

Eating an adequate, balanced diet can help maintain body weight and muscle mass and improve immune function. Food can be divided into four groups, according to its dominant nutrient content: carbohydrates, fats, proteins, and vitamins and minerals.

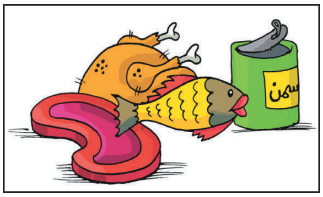


Foods rich in carbohydrates

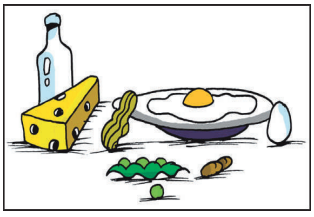
Grains (e.g., corn, wheat, rice, and barley), potatoes, sweet potatoes (batata) and legumes (beans, lentils and peas) as well as starches, sugars, pastries, and fruits such as bananas, dates, figs, grapes and mangoes are rich in carbohydrates. Carbohydrate-rich foods provide the body with energy, and they are usually easy to digest and inexpensive.

Foods rich in fats

Oils, butter, margarine, fatty meats and poultry, and fatty fishes are rich in fats. Like carbohydrates, fats provide the body with energy, but they can be harder to digest than carbohydrates.

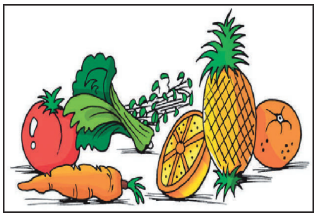


Foods rich in proteins



Meat, chicken, dairy products, eggs, beans (soy and others), lentils, peanuts, peas, and seeds are all rich in proteins. Eating proteins provides the human body with amino acids that support the building of the body and play an important role in the reinforcement of the immune system.

Foods rich in vitamins and minerals



Green leafy vegetables (spinach, molokheya, gargeer), hummus, tomatoes and pumpkin, as well as many fruits (mangoes, oranges, guavas, bananas, peaches

and lemons) provide the body with vitamins and minerals. Each vegetable or fruit is rich only in a few vitamins or minerals, so it is important to eat a variety varied in color, shape, and botanical function, e.g., leaves, fruits, and roots. Generally, dark green and orange or red vegetables and fruits are best.

A healthy meal is made up of at least one food item from each of the four food groups.

Table 4: Example of Foods in the Main Food Groups

Carbohydrates	Protein and Fats	Vitamins and Minerals
Maize (corn) Wheat Bread Sweet potato (*batata*) Rice	Milk Eggs Meats Beans Peanuts	Oranges Bananas Mangoes Pumpkin Green leafy vegetables

Guidelines for safe food handling

- Always wash hands with soap and water before and after touching food.
- Keep hot foods hot and cold foods cold.
- Do not eat food after the "best before" date has passed.
- Be especially careful with leftovers; do not eat them unless they were refrigerated immediately after their initial serving.
- Store cooked foods for no more than a day, and boil them before eating or heat thoroughly.
- Cook all animal products (e.g., meat, fish, and eggs) at a high temperature until well done; do not eat soft-boiled eggs.
- Use only plastic or Formica cutting boards when cutting raw or cooked animal products. Wooden cutting boards cannot be cleaned adequately.

- Wash utensils and surfaces where animal products have been before handling other foods.
- Put meat, poultry, and fish into plastic bags before placing them in your shopping basket. Put them at the bottom of the basket so they will not drip onto other foods.
- Thoroughly wash fruits and vegetables that are to be eaten raw in order to remove bacteria from the skin. Cut off bruised parts. If washing is not possible, peel skin.

Food and diarrhea in people living with HIV/AIDS

People living with HIV/AIDS, especially those who are in an advanced stage of the disease, often experience diarrhea. The main causes are infection (viral or bacterial), poor nutrition, and malabsorption (improper absorption of food in the digestive tract). Proper nutrition can play an important role in both minimizing the causes of diarrhea and treating it.

Selecting foods carefully and following the above mentioned guidelines for food handling can significantly reduce the risk of infection-related and malabsorption-related diarrhea. If diarrhea does occur, practical steps can be taken to prevent dehydration (the biggest danger of severe diarrhea) and/or malnutrition (the biggest danger of long-lasting diarrhea). Provide your HIV/AIDS-positive client with the following guidelines:

- Drink a lot of fluids to prevent dehydration.
- Eat five or more small meals a day.
- Eat soft, mashed, liquid foods that are easy to eat and swallow, such as beleela and soup.
- Eat food low in fat. Do not add cooking oil and margarine. Boil food rather than frying. Cut away visible fat from meat and remove the skin from chicken.
- Eat food high in carbohydrates to provide energy, including rice, potatoes, corn and bread.

- Eat soft fruits and vegetables, such as bananas, melons and mashed potatoes.
- Avoid milk and milk products.
- Avoid acidic fruits and vegetables, including onions and tomatoes.
- Do not use “hot” spices like pepper including chili peppers.
- Prepare vegetable soups and stews using a refined meal of rice, barley, or potatoes and soft vegetables such as pumpkin or carrot.
- Prepare food from fresh ingredients. Do not store prepared food and risk food poisoning.

Nutritional supplements

When there is insufficient caloric or protein intake (difficulty maintaining or gaining weight), nutritional supplements may be used. These include blended food products, commercial formulas, intravenous solutions, vitamins, and micronutrients.

Recent studies examining the relationship between a person's micronutrient status and HIV progression suggest that vitamins A, B-complex, C, E, and niacin, and the mineral selenium, may be helpful in replenishing absent nutrients in people with HIV/AIDS. The role of other micronutrients, such as iron, zinc, and other antioxidants are useful for the human body; however, high intake of these may be harmful. Multivitamin and mineral supplements are recommended only if an individual is unable to obtain an adequate balance of nutrients through diet.

Golden Rules for Good Nutrition

Eating healthy and avoiding substances that are harmful to one’s health (such as alcohol and tobacco) can help improve immune function in PLHA. Important aspects of healthy eating include:

- Eating whole (unpreserved) food
- Eating natural (unprocessed) food

- Eating fresh, in-season food
- Drinking clean water, boil for 10 minutes or filter it
- Eating small but frequent meals – five or more daily
- What to eat:
  - 50 percent whole carbohydrates
  - 30 percent vegetables
  - 15 percent proteins
  - 5 percent other (fruits and dairy products)
- What to avoid:
  - Sugar and all foods containing sugar
  - Fats, especially in the presence of diarrhea
  - Canned, processed and/or refined foods
- Seek professional help for nutritional questions and/or persistent diarrhea

Stigma

HIV/AIDS is a condition that continues to generate fear, misunderstanding, misinformation, and discrimination. There are few nurses and caregivers in the world that have not been affected in some way by HIV/AIDS.

How the stigma manifests itself in our communities

- HIV/AIDS = DEATH
- HIV/AIDS = PROMISCUITY/IMMORALITY (sex outside of marriage)
- The HIV/AIDS stigma is particularly pertinent to women when men desert them, beat them or accuse them of being the "carriers of HIV"
- People living with HIV/AIDS = "Untouchables"; neglected, with their rights to care and support violated

How discrimination manifests itself in our communities

- Abuse
- Loss of work

- Loss of potential employment
- Teasing/upsetting/harassing
- Isolating/rejecting/neglecting
- Loss of friends
- Loss of partner/family
- Denial of access to resources including health care

Activity : Questions for reflection and discussion

- What fears or misunderstandings do you have?
- How might these fears or misunderstandings affect you?
- Where do you think these fears/misunderstandings come from?
- How might you overcome these fears/misunderstandings in order to provide care, support, counseling, education, and advice in the prevention and care of HIV?
- How might you influence others in their care of people living with HIV/AIDS and their families?
- How do you see your role in providing and promoting safe, moral and ethical care to people living with HIV/AIDS and their care givers/ families/communities?

Experiences of fear, stigma, isolation, and discrimination come from:

- Misinformation about HIV transmission.
- Fear of contracting HIV.
- Fear of caring for people living with HIV/AIDS.
- Religious teachings and influences related to sexuality and birth control.
- The cultural norms of silence regarding sexual practices, preferences and desires.
- Legal issues related to the misuse of legal and illegal substances.

- Legal issues related to other practices including prostitution and homosexuality.

Compromised care

Negative attitudes, beliefs and values, or misinformation about HIV significantly limit a caregiver's ability to provide effective, respectful and dignified care for PLHA and their families. Some documented negative behaviors of health care workers include:

- Condemning the PLHA (referring to them as a "bad person" or "careless person").
- Isolating or avoiding the PLHA because of embarrassment or not knowing how to handle the situation.
- Refusing to treat or care for the PLHA or his/her family.
- Reluctance to disclose one's own HIV-positive status to other health care workers for fear of discrimination, isolation, and condemnation.
- Inability to discuss sexual practices, preferences and desires because of embarrassment, shame or guilt.
- Ignoring or avoiding discussion and counseling about risky behaviors and HIV prevention and care.
- Inability or unwillingness to approach the PLHA and family in a non-judgmental, caring and supportive manner.

HIV/AIDS Status Disclosure

People living with HIV/AIDS may require assistance from counselors in relation to disclosing their HIV sero-status to their families, husbands/wives and/or others. Disclosure can bring about both positive and negative effects. Some individuals may be keen to publicly disclose because they have observed the benefits to some colleagues such as financial gain, attendance at conferences, seminars, and international travel. However, this has also created rivalry, infighting and competition within groups. Motivations for disclosure

vary greatly, and debates about “degrees of disclosure” have been evoked. We still have a lot to learn about the complexities of disclosure.

The advantages, disadvantages and degree of disclosure desired should be explored in depth with PLHA. Counselors can assist clients with this process. UNAIDS/WHO encourage “beneficial disclosure”. This disclosure:

- Is voluntary.
- Respects the autonomy and dignity of the affected individuals.
- Maintains confidentiality as appropriate.
- Leads to beneficial results for that individual, his/her partner/s and family.
- Leads to greater openness in the community about HIV/AIDS.
- Meets the ethical imperatives of situations where there is a need to prevent onward transmission of HIV.

Strategies to overcome barriers to disclosure

- We need more community support to speak openly about HIV.
- We need high profile people to publicly disclose as role models.
- We need to enforce legislation relating to discrimination in order to reduce stigma/shame/discrimination.
- We need to further promote VCT services that offer linkages to a range of care and support services.
- We need to involve religious organizations and community based programs. They have an important role to play in promoting VCT services and status disclosure within families, marriages, and communities so that people can be further supported to live positively and enhance the quality of their lives.
- We need to dialogue further on experiences of stigma within VCT and status disclosure.
- We need to ensure increased and improved access to treatment to invoke strategies of hope.

Chapter 8

Ethical Issues

Ethical Issues

Ethical issues in HIV/AIDS prevention and care include:

- The ethical duty of medical personnel to provide care.
- The responsibility of HIV positive health workers to protect their patients.
- In situations where HIV/AIDS and human sexuality cannot be discussed openly, doctors, nurses and counselors may feel embarrassed and uncomfortable about discussing sexual issues or may totally ignore this topic during health education sessions. This behavior brings about the conspiracy of silence and ignorance. Health care workers should be prepared to break with tradition and to accept and provide counseling and education about this topic.
- Health care workers must be perceived as competent professionals, capable of discussing issues openly and confidently and of acting fairly and compassionately. If health care workers become role models for open and compassionate behavior, others will soon follow their example.
- An important aspect of attending to the care needs of PLHA is to advocate for compassionate, dignified and competent care for our own HIV positive colleagues.

Ethics in Counseling

Case study

You are a counselor who has been seeing a couple who were tested. They were tested separately and returned separately for the results. The man tested negative and the woman positive. The woman refuses to disclose her status to her husband-to-be. What are the issues? How do you respond?

Ethics

A code of ethics outlines the fundamental values of counseling. As counselors we should have knowledge of these values so that we are guided to maintain a professional relationship with our clients. Below is a list of ethical principles to which counselors should adhere.

Ethical principles in counseling

- The counselor must make sure that the client does not suffer physical or psychological harm during counseling.
- The counselor must maintain respect for the client in the counseling relationship by avoiding engaging in activities that seek to meet the counselor's personal needs at the expense of the client. Sexual harassment, unfairness, discrimination, stigmatization, and offensive remarks must be avoided.
- The counselor is responsible for his/her own physical safety. He/she is also responsible concerning his/her effectiveness and competence, as well as his/her conduct so as not to compromise the counseling profession.
- The counselor should be aware of the laws governing counseling in the community and make sure that he/she works within these laws.
- The counselor must ensure that he/she has received sufficient training in counseling skills and techniques.
- The counselor must work within his/her limits of competence and be willing to make appropriate referrals whenever necessary.
- Each counselor must recognize his/her boundaries of competence and provide only those services and use only those skills and techniques for which he/she is qualified by training and practice.
- Counselors should monitor their competence and limitations through counseling supervision or consultative support and by seeking the views of their clients and other counselors.

- Counselors are also responsible for other counselors and must stand to correct others when appropriate.
- The counselor has a responsibility both to the individual clients and to the institution within which the counseling service is performed to maintain a high standard of professional conduct.
- The counselor must strive to promote the client's control over his/her own life, and respect the client's ability to make decisions and change in the light of their own beliefs and values.
- The client is responsible for his/her own actions and eventual results.

Informed Consent and Confidentiality

- Anyone taking an HIV test must give informed consent prior to being tested. Confidentiality must be upheld and no information concerning the client should be given out without the permission of the client.
- The results of the test must be kept absolutely confidential. The only individuals who may have access to knowledge of HIV test results are the counselor and any other health or community worker who has a direct clinical or care relationship with the client, e.g., referring physician, laboratory technologist, etc. The client may also determine with whom they wish to share their confidentiality, e.g., a relative, friend, or spouse, etc...
- The counselor must treat all information and/or material heard, obtained or provided in the counseling relationship as confidential.
- The counselor must encourage the client to choose, without persuasion, whether or not to enter into counseling.
- Counseling is voluntarily (unless sanctioned through legal channels on criminal or mental health grounds) and deliberately undertaken by the counselor and client, and it should take place in a private and confidential setting.

- It is the counselor's responsibility to inform the client about the nature of counseling offered and contractual obligations, i.e., timing, duration, confidentiality, etc...
- The counselor must take all reasonable steps to communicate clearly the extent of confidentiality they are offering to clients. Normally, this should be made clear during pre-test counseling.
- The counselor must not disclose any information about the client to colleagues or a third party without first seeking consent of the client.
- The counselor must treat with confidentiality personal information about clients whether obtained directly or indirectly. It is good practice to avoid identifying specific clients during counseling supervision, consultative support and other consultations, unless there is sound reason for doing so.
- The counselor must make provisions for maintaining confidentiality in the storage and disposal of client records.
- The counselor may break the agreement about confidentiality only if there is sound reason to do so, including:
  - ◇ A belief that the client will cause serious physical harm to him/herself or to other persons, or have harm caused to him/her.
  - ◇ A belief that the client is no longer able to take responsibility for his/her decisions and actions.
- The decision to break a confidentiality agreement between a counselor and client should be made only after thorough consultation with a counseling supervisor or an experienced counselor.
- It is sometimes argued that in a medical emergency, the consent requirement can be ignored and that health workers may have to know the patient's HIV status in order to protect themselves.

- Non-consensual HIV testing cannot be justified in these circumstances because:
  - ◇ The risk of occupational transmission of HIV is extremely small and elementary precautions can eliminate it.
  - ◇ In an emergency there is no time to get the results of the test before surgery.
  - ◇ During the window period an HIV test result will not indicate if a person has the virus. This HIV test result cannot be relied on to decide on medical procedures and precautions during surgery.

Counselors may find themselves caught between conflicting ethical principles. In these circumstances they are urged to discuss the situation with their supervisor or senior counselor. Even after consultation and supervision, some ethical dilemmas cannot be resolved easily or in a completely satisfactory manner.

Chapter 9

Record Keeping

Record Keeping

Record keeping is a vital part of VCT service delivery. It is important to keep adequate accurate records because:

- Records provide vital information in relation to service operation.
- Records are used to gather statistics which help to determine if the service is meeting its clients needs and if the service is having an impact.
- Records assist in revealing gaps in service provision.
- Records can be revisited as required to strengthen service provision.
- Records may be required as legal documents in some circumstances.
- Records play a role in the continuum of care for clients within a service and beyond (via referrals).
- Records play an important role in quality assurance of a service.
- Records can provide important information in future service planning.

Standardized record keeping formats should be developed. This allows for the synthesis of data and evaluation for overall program analysis across and between sites. Alternatively, if some sites have specific needs for information, they may choose to adapt the national formats for their needs or create an additional form (though essential statistical data should be retained for broader analysis as required).

Potential record keeping formats for VCT might include:

- VCT Log book
- Witnessed Informed Consent Form for HIV testing
- VCT Client Intake Form
- HIV Laboratory Request Form
- Rapid Test Kits Inventory Form

- Condom Inventory Form
- IEC Materials Inventory Form
- VCT Service Request for Referral
- VCT Client Exit Questionnaire
- Checklist for Conducting Direct Observation of Counseling Session
- Monthly report

Chapter 10

Monitoring and Evaluation and Quality Assurance

Monitoring and Evaluation and Quality Assurance

Monitoring and evaluation (M&E) is a critical component of the successful implementation of VCT services. Well designed and conducted M&E of VCT will help identify and correct potential problems on an ongoing basis and provide feedback during the process of planning, designing, and implementing programs.

Monitoring and evaluation activities should address:

- Service delivery – how well VCT is provided.
- Program effectiveness – the intermediate outcomes and long-term impact that VCT may have on the population receiving the service.

Sample Indicators Include:

Process indicators: service delivery/program output

- Proportion of people in the community who know about HIV VCT services.
- Number of people counseled and tested at the VCT site (per month, per year).
- Proportion of people counseled and tested who have returned to receive their test results.
- Proportion of people testing HIV positive who have been referred to appropriate care and support services.
- Proportion of people counseled and tested who state that they intend to inform their partners.
- Proportion of people counseled and tested who have informed their partners (partner notification).

Effectiveness indicators: intermediate program outcomes

- Changes in HIV/STI-related risk behavior among VCT clients and their partners.
- Changes in behavior among people stating that they know their sero-status (collected through a Behavioral Surveillance Survey (BSS), for example).
- Changes in STI trends in sub-populations reached by the VCT program.
- Reduced stigmatization of, and discrimination against, people in the community affected by HIV/AIDS.
- Increased community support for people living with HIV/AIDS.

Effectiveness indicators: expected program impact (long-term effects)

- Changes in trends in HIV incidence/prevalence in the population or sub-populations served by VCT programs.
- Reduced mother-to-child transmission of HIV infection in women of childbearing age targeted by the VCT programs.
- Sustained changes in societal norms in the community reached by VCT programs.

Quality Assurance

Quality assurance of both HIV testing and counseling is critical to the success of VCT services. Implementation of quality assurance includes:

- Development of standard operating procedures
- Training
- Supervision and support of staff
- Establishment of both internal and external quality control systems for both counseling and testing

Quality means a variety of different things to different people. For some people, the accessibility of the service or the accuracy of the test results received is of utmost importance; while for others, the way the providers treat them and the privacy that is afforded are the key elements in deciding whether to use the service again or to recommend it to others. Long waiting times or finding that services are unavailable after seeking them out may hinder quality significantly. Similarly, receiving ambiguous or inconsistent information during a counseling session may frustrate or confuse clients and prevent them from making informed decisions. The counselor who fails to help clients to address their feelings or who hurries to gain resolution rather than allowing time to explore and understand the client's needs and concerns might also be perceived as providing poor quality service.

Standards of quality should be defined within the program design, the program indicators and staff job descriptions. The service design must define standards for a VCT program and ensure that the staff understands what is meant by “quality” and why it is meaningful. A trainer/supervisor could encourage site staff to define what quality means to them and to list the type of services they would expect or desire if they themselves (or their mother, father, spouse, sister or brother) attended the VCT site. The responses can be compared with the quality assurance measures that have been designed for the specific program.

Common guiding principles for promoting quality within VCT services include:

- Ensure that VCT services meet the needs of its beneficiaries.
- Make quality of care the culture of the institution.
- Educate clients to expect quality of care as their “right”.
- Use systems and tools to monitor and evaluate the quality of service provision.

- Promote staff involvement and ownership in the quality assurance process including the provision of time and support for staff to come together to discuss strategies for improving the quality of service.
- Ensure that quality assurance is a continuous process (as there is always something to improve and it is also necessary to maintain past gains).

In order to ensure high-quality service provision, it is necessary to provide:

- Continuous capacity development of VCT staff (opportunities for training updates, exchange visits, and peer support mechanisms) to strengthen their service delivery.
- Specified roles, responsibilities and capacity building for individuals to conduct regular supportive supervision of both counseling and testing activities, (e.g., senior counselors, site managers who have a counseling background, laboratory technicians, etc.). Supervision is a quality assurance mechanism through which a supervisor ensures that staff provides services of a specified standard of quality and competency.
- Reward quality work through: (e.g., letter of recognition for service, "counselor of the year" awards, meal provision, time off, promotion opportunities, etc.) as motivation to impact upon staff performance.

The objectives of quality assurance measures for VCT are to assess staff performance, client satisfaction and adequacy of both the counseling and testing protocols.

Quality assurance measures

- Regular site visits (to observe operating procedures and client/staff interactions).
- Refresher training, stress management, skills building, and exchange visits.

- Self and/or peer review of a counseling session.
- External observation of a counseling session (with client consent).
- Supportive supervision.
- Feedback from clients via client exit surveys.

Evaluating Counselor Performance

In order to maintain and monitor the quality of counseling, various strategies should be applied including regular training of counselors and direct observation of counseling sessions. Direct observation is a commonly used method to monitor the quality of counseling. It is conducted by a trained observer or site manager – who observes the counseling session while using a checklist. The purpose of this approach is to determine if the counseling session is being conducted in a standardized fashion and to identify further training needs of the counselors.

In de-briefing a counselor or for the purpose of role-play ask the following questions:

- How did the client feel the session went? Would he/she come back?
- How did the counselor feel the session went? In what ways does he/she feel the session could have been improved?

Note: It is possible that the counselor will not be able to cover some of the above points due to the emotional state of the client. In such circumstances, the counselor should, at the very least, provide written information for the client to take away (including referral sources) and encourage the client to return at a more appropriate time as soon as possible.

Client exit survey

It is recommended that a self-administered Client Exit Survey be provided to ten percent of all clients (or every tenth client). Forms can be placed either in the waiting area or the reception area of the site. Willing clients should complete this form and deposit it in the site's suggestion box to be collected at the end of the day.

- In cases of illiterate clients who are willing to complete the form, a staff member who did not have contact with the client should assist him/her in completing the form. Again, this form should be deposited in the suggestion box, but with an indication that staff assisted in completion of the form.

Note: Some clients do not wish to fill in surveys upon leaving a site resulting in a low response rate. An alternative is for a designated staff member or external evaluator (who did not have contact with the client/s) to request to meet briefly with clients at a suitable time to elicit feedback on their perception of the service they received.

Client interviews should be brief and focus on the following key issues:

- Do clients receive the services they come for?
- Do they get information related to the service they received?
- What do they like best about the facility?
- What do they like least about the facility?
- What are their suggestions for improving services?

The survey can be given randomly to clients to fill out before they leave the site. They must be aware that the form is brief, can be completed within 5-10 minutes, and is anonymous (no contact details are required). Clients must be told that their suggestions will be considered in order to help improve the services at the facility. There may be bias in results of exit surveys due to the possibility of some clients being unwilling to provide negative feedback.

Laboratory testing protocols

- Staff is trained on the specific protocol adopted for use in their VCT program. The training should include the standard procedure for drawing blood, i.e., via the finger prick methodology or by phlebotomy, handling specimens, disposal of bio-hazardous materials and transporting of samples (if applicable).

- All positive samples tested during screening will be retested for confirmation using a test kit with different antigens and principles.
- The Central Laboratory operates as the official External Quality Assurance agency for all HIV testing in Egypt.
- Internal quality control of all HIV test samples maintained onsite will be conducted on a daily basis.
- Test kits will be stored properly and cannot be used following the date of expiration.
- If applicable, the local VCT team coordinator should meet regularly with a designated National Reference Laboratory staff member to review the designated HIV testing protocol and to address the following questions:
  - ◇ How consistently is the protocol used?
  - ◇ How valid is the testing algorithm in terms of specificity and sensitivity?
  - ◇ How long are clients waiting to receive their test result? Are clients comfortable with the waiting period?
  - ◇ Is the testing protocol the most appropriate given local conditions? If not, how can it be improved?

Chapter 11

Referrals and Linkages with Services and Service Providers

Referrals and Linkages with Services and Service Providers

Why is Referral for VCT Services Required?

Referral for VCT services is a two way process that creates linkages with both the community and clinical based organizations. Cooperation with other service providers that can identify and direct clients to appropriate community services will also benefit people in need of care. These linkages will ensure support for clients who have received VCT services and referrals from the community to the VCT sites for those who want to know their sero-status.

Following high quality VCT a large percentage (perhaps 80%) of clients benefit sufficiently enough not to require further intervention. For instance, for clients testing negative it is generally possible to accurately determine risk level, optimize behavior, and minimize risk in the long term during VCT. Even among those receiving positive results, a portion of them have the resources to psychologically adjust to a HIV positive status and live positively, and disclose HIV positive results to a partner and support system. However, some clients will require referral for a number of reasons.

Staff at each VCT site should adhere to the following:

- Develop, update and keep an inventory of available prevention, care and support services available.
- Develop a formal referral system to community services.
- Develop and build formal linkages with community organizations.
- Refer clients to community support groups as determined by the client's needs and availability.
- Participate in local community mobilization/support efforts.

Definition of Referral

In the context of HIV prevention counseling and testing, referral is the process by which the client's immediate needs for care and supportive services are assessed and prioritized and clients are provided with assistance (e.g., setting up appointments, providing information on how a client can get to a particular place, etc.) in accessing services. Referral should also include reasonable follow-up efforts necessary to facilitate initial contact with care and support service providers. For this reason, once a referral has been made, the client moves from an anonymous setting, into one where his anonymity cannot be maintained, but where his confidentiality must be ensured.

Reasons for Referrals

Clients may have complex needs that affect their ability to adopt and sustain behavior that reduces their risk for transmission or acquisition of HIV. Clients with HIV may need medical evaluation, care and treatment for OIs and communicable diseases such as tuberculosis, hepatitis and other STIs. Other clients needing referrals may include:

- Those addicted to drugs and/or alcohol.
- Those with mental illnesses, developmental disabilities or difficulty coping with an HIV diagnosis or HIV-related illnesses.
- HIV-positive pregnant women.
- Clients who need legal services to prevent discrimination in employment, housing or public accommodation.
- Those who require individual counseling.
- Those who require relationship counseling.
- Clients who need family counseling.
- Clients who need spiritual counseling.
- Those who require access to social services.

Some clients may need assistance with housing, food, employment, childcare and domestic violence. Addressing these needs can assist clients in accessing and accepting medical services and in facilitating the adoption and maintenance of behavior to reduce the risk of transmission and/or acquisition of HIV.

Counselors must be aware of the limitations of the services they can offer. These limitations should be clearly explained to clients so that they do not feel rejected when counselors make a referral. Counselors can refer clients during the pre-test stage or the post-test session.

How to make a successful referral

- Assessment should include examination of the client's willingness and ability to accept and complete a referral.
- Service referrals that match the client's self-identified priority needs are most likely to be successfully completed.
- Work with clients to decide what their immediate referral needs may be (Please remember that you can refer even during the pre-test counseling stage).
- Outline the options available and help the client choose the most suitable, in terms of distance, cost, and the client's culture, language, gender, sexual orientation, age and developmental level.
- In consultation with the client, assess what factors may make it difficult for the client to complete the referral, (e.g., lack of transportation or childcare, work schedule, cost, etc.) and address such factors as possible.
- Inform the client of the possible need to move from anonymity to confidentiality, depending on the type of referral indicated.
- Make a note of the referral in the client's record. Ensure follow-up and monitor the referral process.
- Give the client a list of services with addresses, telephone numbers and hours of operation.

- Invite the client to give feedback on the quality of services to which he/she is referred.
- Be aware of community support groups located near the counseling site, services offered, hours of operation, and contact persons.

In certain cases it may be more appropriate to refer clients to a member of their family, a friend or a sexual partner. Counselors should discuss the matter with the client to identify a suitable person. If possible, counselors should meet with the person before sending the client to meet with him/her.

Basic Elements of a Good Referral

- Clear, specific and up-to-date information
- Confidentiality
- Safe and easy accessibility
- Provision of several options to the client
- Creation of a system for clear communication between the counselor and the services to which clients are referred
- Absence of discriminatory practices by service providers
- Documentation of referral and follow-up

Documenting Referral and Follow-up

Providers should assess and document whether the client accessed the referral services. If the client did not, the provider should determine why not; and if the client did, the provider should determine the client's degree of satisfaction. If the services were unsatisfactory, the provider should offer additional referrals. Information obtained through follow up of referrals can identify barriers to completing the referral, responsiveness of referral services in addressing client needs, and gaps in the referral system.

Provider Coordination and Collaboration

Providers should develop and maintain strong working relationships with other providers and agencies that may be able to provide needed services. Coordination and collaboration should be formally documented. Providers who offer VCT but not a full range of medical and psychosocial support services should develop direct, clearly delineated arrangements with other providers who can offer needed services. Such coordination and collaboration promotes a shared understanding of the specific medical and psychosocial needs of clients requiring services, current resources available to address these needs, and gaps in resources. Providers should maintain accurate and current information regarding referral services.

Knowledge of available support services is essential to facilitating successful referrals. Some services may not be available locally. Where referral resources are not available locally, providers should make every effort to identify appropriate resources and link clients with these resources. A resource guide should be developed and maintained to assist staff in making appropriate referrals.

Contents of Referral Resource Guide

For each resource, the referral resource guide should specify:

- Name of the provider or agency
- Range of services provided
- Clients served
- Contact names, telephone, fax numbers, street addresses, and e-mail addresses
- Hours of operation
- Location
- Cost for services and methods of payment
- Admission policies and procedures
- Directions, transportation information and accessibility to public transportation

Appendices

Appendix A: Witnessed Informed Consent Form for HIV Testing

Appendix B: VCT Client Intake Form

Appendix C: Checklist for Direct Observation of Counseling Sessions

Appendix D: VCT Service Request for Referral

Appendix E: VCT Client Exit Questionnaire

Appendix A:

Client Code:

WITNESSED INFORMED CONSENT FORM FOR HIV TESTING

This is to state that I have been counseled about the HIV test to be conducted and the implications of the test results.

All details pertaining to HIV ··· how it is transmitted, what the testing procedures are, and how to interpret the test results ·· have been explained to me in a manner that I can understand.

I also understand that I am free to refuse the test and still get the help I need from this site without being discriminated against.

I hereby give my consent for the test to be conducted so that I may know my HIV status.

Counselor Name: .....

Counselor Signature: .....

Date .....

Witness (Coordinator) Name: .....

Witness Signature: .....

Date: .....

Appendix B: VCT Client Intake Form

Client Code: ____

Date: **Governorate:** **District:** **Site:**

Return Visit 1 ☐ Yes 2 ☐ No **New Code** 1 ☐ Yes 2 ☐ No **Partner Code:** **Code name:**

1. Age: ____
1 ☐ <16 years
2 ☐ 16-24 years
3 ☐ 25-35 years
4 ☐ >35 years

2. Gender:
1 ☐ Male 2 ☐ Female

3. Occupation: (Tick one)
1 ☐ Unemployed
2 ☐ Student
3 ☐ Craftsman
4 ☐ Professional
5 ☐ Other
Specify: ____

4. Education: (Tick one)
1 ☐ None
2 ☐ Some primary
3 ☐ Some preparatory
4 ☐ Some secondary
5 ☐ Some university
6 ☐ University

5. Marital status: (Tick one)
1 ☐ Never married
2 ☐ Steady partner, not living together
3 ☐ Steady partner, living together
4 ☐ Married, monogamous
5 ☐ Married, polygamous
6 ☐ Widowed
7 ☐ Separated / divorced

6. Pregnant: (Tick one)
1 ☐ Yes
2 ☐ No
3 ☐ Don't know
9 ☐ N/A

7. Service Required: (Tick one)
1 ☐ Information only
2 ☐ Counseling
3 ☐ Full VCT service

8. Client Counseled as: (Tick one)
1 ☐ Individual
2 ☐ Couple

9. Why being tested today: (Tick all that apply)
1 ☐ Plan to get married
2 ☐ Study/work permit
3 ☐ Client risk behaviour
4 ☐ Partner risk behaviour
5 ☐ Had blood transfusion
6 ☐ Injecting Drug User
7 ☐ New sexual partner
8 ☐ Tested elsewhere
9 ☐ Referred by health worker
10 ☐ Other - Please specify: ____

10. How did client learn about this service: (Tick all that apply)
1 ☐ Television
2 ☐ Radio
3 ☐ Newspaper
4 ☐ Poster / sign post
5 ☐ Pamphlets
6 ☐ Relative / friend
7 ☐ Sex partner / spouse
8 ☐ Another VCT client
9 ☐ Health facility/worker
10 ☐ Hotline
11 ☐ Other - Please specify: ____

11. Sex in last 6 months? (Tick one)
1 ☐ Yes
2 ☐ No (Go to Question 14)

12. No. of sex partners over past 6 months:
Women sex partners: ____
Men sex partners: ____

13. Condom use in last 6 months: (Tick one per partner)
Steady Partner:
0 ☐ Never
1 ☐ Sometimes
2 ☐ Always

Non - steady partner:
0 ☐ Never
1 ☐ Sometimes
2 ☐ Always

14. Used condom last time had sex: (Tick one)
1 ☐ Yes
2 ☐ Yes, but condom broke
3 ☐ No
9 ☐ Never had sex

15. Used injecting drugs?
1 ☐ Yes 2 ☐ No

16. Exchanged sex for drugs?
1 ☐ Yes 2 ☐ No

17. Has client had an HIV test before? (Tick one)
1 ☐ Yes, negative
2 ☐ Yes, positive
3 ☐ Yes, do not know result
4 ☐ No

18. Condoms given? ____
(Tick one and mention number):
1 ☐ Yes, with demo
2 ☐ Yes, without demo
3 ☐ No, with demo
4 ☐ Refused
5 ☐ Condoms not available

19. IEC materials given?
1 ☐ Yes ☐
2 ☐ No ☐

20. Pre-test counseling completed?
1 ☐ Yes
2 ☐ No

21. HIV Result today:
Screening Test: Rapid Test
0 ☐ Negative
1 ☐ Positive
9 ☐ Not done

Screening Test: ELISA 1
0 ☐ Negative
1 ☐ Positive
9 ☐ Not done

ELISA 2:
0 ☐ Negative
1 ☐ Positive
9 ☐ Not done

Confirmatory: Western Blot
0 ☐ Negative
1 ☐ Positive
2 ☐ Indeterminate
9 ☐ Not done

Final Diagnosis:
0 ☐ Negative
1 ☐ Positive
2 ☐ Indeterminate

22. Test results received by client?
1 ☐ Yes 2 ☐ No

23. Intend to share results with partner?
1 ☐ Yes 2 ☐ No
3 ☐ N/A

24. Referred to: (Tick all that apply)
0 ☐ Not referred
1 ☐ HIV clinician
2 ☐ STI services
3 ☐ TB services
4 ☐ Ongoing counseling
5 ☐ Spiritual support
6 ☐ Other - Please specify: ____

25. Post-test counseling completed?
1 ☐ Yes 2 ☐ No

Appendix C:

VCT Checklist for Direct Observation of Counseling Sessions

Section 1: Skills of Counselor

Function	*Skills*	*Score**	*Comments*
Interpersonal relationship	• Greets clients	1 2 3	
	• Introduces self	1 2 3	
	• Engages client in conversation	1 2 3	
	• Listens actively (both verbally and non-verbally)	1 2 3	
	• Is supportive and non-judgmental	1 2 3	
Information gathering	• Uses appropriate balance of open and closed questions	1 2 3	
	• Uses silence well to allow for self expression	1 2 3	
	• Seeks clarification about information given	1 2 3	
	• Avoids premature conclusions	1 2 3	
	• Probes appropriately	1 2 3	
	• Summarizes main issues discussed	1 2 3	
Information giving	• Gives information in clear and simple terms	1 2 3	
	• Gives client time to absorb information and to respond	1 2 3	
	• Has up-to-date knowledge about HIV	1 2 3	
	• Repeats and reinforces important information	1 2 3	
	• Checks for understanding/misunderstanding	1 2 3	
	• Summarizes main issues	1 2 3	
Handling special circumstances	• Accommodates language difficulties	1 2 3	
	• Talks about sensitive issues plainly and appropriate to the culture	1 2 3	
	• Prioritizes issues to cope with limited time in short contacts	1 2 3	
	• Uses silences well to deal with difficult emotions	1 2 3	
	• Is innovative in overcoming constraints, (e.g., space for privacy	1 2 3	
	• Manages client's distress	1 2 3	
	• Flexible in involving partner or significant other	1 2 3	

*** Circle appropriate score: 1 = poor 2 = adequate 3 = excellent**

Name of Counselor: .....

Supervisor Signature: .....

Date: .....

Section 2: Content-Based Assessment

2.1 Pre-test counseling

During the session have the following occurred?

- Confidentiality adequately addressed Yes ☐ No ☐
- Reason for attending discussed Yes ☐ No ☐
- Knowledge about HIV and modes of transmission explored Yes ☐ No ☐
- Misconceptions corrected Yes ☐ No ☐
- Assessment of personal risk profile carried out Yes ☐ No ☐
- Information concerning the HIV test given (e.g. process of testing, meaning of possible test results, window period) Yes ☐ No ☐
- Discussion of meaning of HIV positive and negative results and possible implications Yes ☐ No ☐
- Capacity to cope with HIV positive result Yes ☐ No ☐
- Discussion of potential needs and available support Yes ☐ No ☐
- Discussion of a personal risk reduction plan Yes ☐ No ☐
- Time allowed to think through issues Yes ☐ No ☐
- Informed consent/dissent given freely Yes ☐ No ☐
- Follow-up arrangements discussed Yes ☐ No ☐
- Adequate time for questions and clarifications Yes ☐ No ☐
- Did the session end in a positive manner

2.2 Post-test counseling

During the session have the following occurred?

- Results given simply and clearly Yes ☐ No ☐
- Time allowed for client to absorb the result Yes ☐ No ☐
- Checking for understanding Yes ☐ No ☐
- Discussion of the meaning of the result for the client Yes ☐ No ☐
- Discussion of personal, family and social implications, including who, if anyone, to tell Yes ☐ No ☐
- Discussion of a personal risk reduction plan Yes ☐ No ☐
- Dealing with immediate emotional reactions Yes ☐ No ☐
- Checking if adequate immediate support is available Yes ☐ No ☐
- Discussion of follow-up care and support Yes ☐ No ☐
- Options and resources identified Yes ☐ No ☐
- Immediate plans, intentions and actions reviewed Yes ☐ No ☐
- Follow-up plans discussed and referrals where necessary Yes ☐ No ☐

Name of Counselor: .....

Supervisor Signature: ..... Date: .....

Appendix D:

VCT SERVICE REQUEST FOR REFERRAL

Client Code: ☐

VCT SERVICE REQUEST FOR REFERRAL

1. NAME OF SERVICE TO WHICH REFERRED:

2. REASONS FOR REFERRAL:

3. REFERRED BY COUNSELOR:

   Name: .....

   Signature: .....

   Date: .....

Appendix E:

VCT CLIENT EXIT QUESTIONNAIRE

Date: .....

Type of visit: **Pre-test** ☐ **Follow-up** ☐

If survey declined, reason for declining:

.....

Type of session: **Individual** ☐ **Couple** ☐

Indicate your answer by circling the appropriate answer to the statements below.

		Yes	No
1	Overall the services I received at the VCT site were satisfactory	1	2
2	A staff member greeted me upon my arrival	1	2
3	I was able to see someone within 30 minutes of my arrival	1	2
4	I had a place to sit while I was waiting	1	2
5	I talked about having an HIV test with my counselor (pre-test visits only)	1	2
6	I talked about receiving HIV test results with my counselor	1	2
7	I talked about issues arising from previous and/or current HIV test result(s)	1	2
8	The counselor made me comfortable talking to him or her	1	2
9	I felt that the confidentiality of my test results/information was well guarded	1	2
10	I felt all my questions were welcomed and answered	1	2
11	In this visit I gained practical guidance on dealing with HIV/AIDS issues	1	2
12	I intend to discuss the results of my test with my partner	1	2
13	I learnt something new from the video and/or brochures in the waiting room	1	2
14	I intend to tell others about this service	1	2

Additional comments:

.....

.....

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