THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH

A GUIDELINE FOR COUNSELLORS IN TANZANIA WITH SPECIAL EMPHASIS ON HIV/AIDS/STDs COUNSELLING

First Edition 1993

Revised Version 1999

NATIONAL AIDS CONTROL PROGRAMME

June, 1999

ISBN-9987-650-10-4

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FOREWORD

Counselling has become a keyword and an essential activity in prevention and control of HIV/AIDS in Tanzania.

Since November, 1995. The National AIDS Control Programme in the Ministry of Health has conducted a number of counselling workshops in order to train counsellors nation wide. Counselling as such is not a new service but on issues related to HIV/AIDS, new principles may be applied.

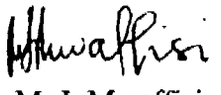
This guideline is intended to assist all people committed to Counselling and Health Education. NACP is well aware that we have to rely on professionals as well as lay counsellors. Since many aspects of prevention and control of AIDS remain controlversial, it is crucial to involve local people knowing the local language, cultural aspects and beliefs to ensure counselling service is respecting different people with different background.

The objective of this counselling guideline is to provide important information on AIDS, how to care for HIV infected people and AIDS patients, counselling techniques, problems faced by the Counsellors and finally, some real stories indicating the process of Conselling.

This Second edition might not cover all the needs and tools required for sufficient and adequate counselling. We therefore, welcome any criticism or comment that could improve the guideline.

We kindly request the users to send their ideas and observations to the NAtional AIDS Control Programme, Ministry of Health, P.O. Box 11857, Dar es Salaam, Tanzania

Let me express my personal appreciation and thanks to all people who have committed themselves in the demanding work to be done for all those being affected by HIV infection and AIDS.



M. J. Mwaffisi
Permanent Secretary
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PREFACE

The HIV/AIDS epidemic is one of the most studied areas in the country, although it has been realised that the disease is not only a biomedical problem. It also has a psycho-social, economical and moral dimension.

The fight against the disease has already involved Government, religious institutions non-Governmental organizations (NGOs) families and individuals. Moreover the NACP has achieved the commitment among the entire population on creating awareness to understanding the HIV/AIDS epidemic.

To promote HIV/AIDS prevention, the National AIDS Control Programme (NACP) has developed this guideline on HIV/AIDS counselling.

Counselling is becoming a routine part of HIV/AIDS management and its objectives are:

a) Improved quality of life for the infected individuals and their relatives.
b) Increased survival among infected patients.
c) Reduce transmission from HIV positive to HIV negative

1.1 The guideline will outline counselling components applying those four objectives.

The guideline also present some case studies from real life. Furthermore, the guideline has been written for use in a wide range of settings at all levels.

It address all counsellors who have the knowledge, skills and attitudes and those willing to adapt the contents of the guideline, to develop the needed skills and take it to the individual patient.

1.2 The National AIDS Control Programme has tried to present the guideline in a simple language so that anybody who is counselling can understand it.

The programme will appreciate suggestions and vivid examples from people practising counselling for future revision of the guideline.

THE AIDS SITUATION.

1. Global situation:

Globally, the HIV/AIDS pandemic continues to sweep across the continents. The number of estimated adult HIV infected world-wide has more than tripled since 1990 from 10 million to over 30.6 million by the end of 1998, that is one in every 100 adults in the sexually active ages of 15 to 49 world-wide. Included in the 30 million figure are 1.1 million children under the age of 15. The overwhelming majority of HIV infected people - more than 90% - live in the developing world, and most of these do not know that they are infected.

Sub-Saharan Africa, representing about 60 per cent of the world's total HIV infections, accounts for almost 90 per cent of the current 20.8 million HIV infections in adult and adolescents in Africa. Of the 5.8 million HIV-infected infants born in the world with HIV infection since the beginning of the pandemic, over 90 percent have been born in Africa.

Data Summary, 1998.

- Adult and children estimated to be living with HIV/AIDS as of end 1998 - 30.6 million.
- Estimated number of adults and children newly infected with HIV during 1998 - 5.8 million.
- Estimated number of deaths in adults due to HIV/AIDS since the beginning of the epidemic, 1996 - 5 million.
- Cumulative number of children estimated to have been orphaned by AIDS at the age of 14 or younger total: 8.2 million.
- Deaths due to HIV/AIDS in 1998 - 2.3 million.
- Cumulative number of deaths due to HIV/AIDS total 11.7 million.

THE IMPACT OF AIDS IN TANZANIA.

AIDS has become a tragedy of devastating proportions in Tanzania.

The lives of infected individuals, their families and communities, the companies they work for, and the country as a whole have been affected by the HIV/AIDS epidemic.

HIV infected persons on average die about 4 to 12 months after becoming symptomatic. During this period a member of the family often has to stay at home or hospital with the patient to provide care, especially during terminal stages of the disease.

The medical, emotional and social cost on the patient and the family are frequently high.

Decades of improvement in social welfare are likely to be undermined by the inhibited progression of the epidemic.

Children will increasingly be pulled into the informal economy to supplement income lost when parents become sick with AIDS or related illnesses. Economic, legal and social inequalities will place women in a more vulnerable position in preventing HIV transmission.

Hospital based data indicate that up to 50% of beds are occupied by patients with HIV/AIDS related illnesses. Consequently the demand on physical care, psychological care and hospital supplies in government health facilities are at breaking point if not broken already due to inadequate funding and manpower.

The World Bank estimates that, because of the AIDS epidemic life expectancy by 2010 would be 47 years instead of 56 years without AIDS. The mean age of the working population (labour force) will decline from 31.5 to 29 between 1992 and 2010.

The overall younger work force would have less education, training and less experience. These factors would have negative impact on the overall economic performance of the country and living standards.

The number of children orphaned by AIDS is estimated to increase from between 260,000 to 360,000 in 1995 to between 490,000 and 680,000 by the year 2000.

Epidemiological situation of HIV/AIDS in Tanzania.

In Tanzania, as in other parts of Africa South of Sahara, transmission of HIV occurs mainly through heterosexual contact beginning in the early ten years peaking before age 30.

Since 1983 when the first 3 AIDS cases were reported, the HIV epidemic has progressed variably in various population groups. Early in the epidemic, urban populations and communities located along highways were most affected. Recently, the epidemic has rapidly spread to rural communities. More than 10% of women attending antenatal clinics situated in rural areas were HIV infected.

The cumulative AIDS cases as reported from surveillance reports in Tanzania mainland rose from 25,503 at the end of 1990 to 88,667 by December 1996. NACP estimates the true number of AIDS cases to be 4 to 6 times of those reported. Therefore, the cumulative number of AIDS cases by the end of 1998 over 550,000.

Extrapolation from these figures in an estimated population of 15,500,000 adults in Tanzania mainland, we could have at least 1,500,000 (or 8.7% population) HIV positives.

According to the blood donor data of 1998, HIV prevalence was high among young adults in the age groups 20 - 24, 25 - 29 and 30 - 34. Infection rates in these groups ranged from 5.9% to 7.9% among moles, and 9.3% to 10.1% among females. Females are affected at an earlier age than men.

Vertical transmission of HIV from mother to child is also considerable. In 1998 this accounted for about 4% of all reported AIDS cases. Data from sentinel surveys in antenatal clinics show seroprevalence rates of 5.5% to 23%, and assuring a 40% prenatal transmission rate, the proportion of new born expected to be infected could reach 7%.

HIV/AIDS is increasingly serious as the underlying factor for hospital admission and deaths. Studies conducted in Dar es Salaam, Hai and Morogoro showed that HIV/AIDS is the leading cause of adult mortality.

Data summary:

1.0 AIDS case reports.

1.1 First 3 cases reported in 1983.

1.2 88,667 cases reported to 31.12. 1996

1.3 109, 863 cases reported so far, by the end of December, 1998.

1.4 Only I out of 4 -6 cases reported.

1.5 The current total number of estimated cumulative AIDS cases stands at about 550,000.

1.6 Exponential increase will continue.

2.0 HIV INFECTION RATES

2.1 Blood donor data

As the number of reporting regions increase, blood donor data is becoming more reliable as a surveillance tool. Due to selection towards those with low HIV infection risk, data from blood donors have increasingly under-estimated the prevalence of HIV infection in the general population

- Estimates show that the prevalence of HIV in the country among adult blood donors is 8.7%.
- The range varies from 7.2% to 20.3%.
- 1998 data, show that HIV prevalence was high among young adults in the age groups 20 - 24, 25 - 29 and 30 - 34.
- 6.8% of the male population and 8.2% of adult female population were HIV infected.
- Most affected regions using prevalence rates for 1998 are:
  Kagera, Iringa, Mbeya - 15% to 20% Dar es Salaam, Rukwa, Shinyanga, Mwanza - 10% to 15%.
  Ruvuma, Kilimanjaro, Mtwara 5% to 10%.

2.2 Antenatal Clinic data:

- Prevalence ranges from 7.5% to 18.7% (1998)
- Based on the current prevalence among pregnant women, it is estimated that about 65,000 (5.1%) of new born babies are HIV positive.

2.3 Orphans

It is estimated that there are over 200,000 orphans, half of them in Kagera region (1997).

PROJECTIONS:

1.0 HIV infections.

- 1,350,000 by the year 1997.
- 1,500,000 by the year 1998
- 3,000,000 by the year 2000.

2.0 AIDS cases:

- 550,000 by the year 1998.
- 1,000,000 by the year 2000.

3.0 Orphans:

- Over 200,000 by the year 1998.
- Probably 1,000,000 by the year 2000.

3. IMPORTANT INFORMATION ON AIDS.

As counsellors you must know the basic facts about HIV infection and its progression. You must keep in mind how you will talk about modes of transmission, signs and symptoms with people from a variety of cultural backgrounds and traditions. Most of all you have to keep in mind that only those who know about HIV/AIDS are able to protect themselves and others to avoid spreading the virus.

3.1 WHAT IS AIDS?

AIDS stands for **ACQUIRED IMMUNE DEFICIENCY SYNDROME.**

Acquired because it is always passed on from another source.

Immune because it is attacks the body's defence system which is called the Immune System.

Deficiency because it keeps the Immune System from working properly.

Syndrome because it causes several kinds of medical problems.

AIDS is caused by a virus a type of germ. This virus is called **HIV** which stands for:

H - Human
I - Immunodeficiency
V - Virus

A person must get the HIV virus into his or her body before they can get AIDS.

Many people are confused about the difference between HIV infection and AIDS. Therefore, it is very important that as a counsellor you are able to explain the differences to your patient. To be infected with HIV virus means that:

(a) You have the virus in your body forever
(b) Your can always pass the HIV virus to others
(c) You can look and feel healthy until you become sick with AIDS and that might take many years.

These are very important aspects of the disease and exactly what makes it so different from any other serious disease. It can be spread unseen among the entire population.

It is crucial to know it is impossible to tell by looking at someone whether he or she is infected with HIV. Some people are infected but do not know it, and anyone who has the virus can transmit it to others. That is why everyone must know the fact about HIV and AIDS so they can act responsibly.

Six people of different disciplines looking healthy but can carry HIV

To be sick with AIDS means:

(a) You cannot fight off germs from other diseases the body loses the ability to get well, even with medicine.
(b) You can still pass the HIV to others.

Sometimes people with AIDS feel and look healthy temporarily, but they can still infect others. You must therefore, motivate your patient to practise safer sex for example in terms of sex with one faithful partner, and use of condom when he or she practises sex. Tell your patient that he or she should avoid casual sex with unknown partner and not have sex with people who are known to have many sexual relationships as prostitutes.

3.2 SIGNS AND SYMPTOMS

Early indications of HIV infection, including physical signs and symptoms may serve as a basis for recommending testing for HIV anti-bodies.

As a counsellor you need to know the most common signs, symptoms and stages of the progression of HIV infection. It will help you to guide and advise your patient in an effective way. But you have to remember that accurate staging of the disease is complicated by the frequent failure of the disease progression to follow a well defined pattern. But the Doctor will help you, in case of doubt.

The first manifestation of HIV infection may be an acute influenza- like illness often unrecognized then followed by a long period without any symptoms at all.

If people develop AIDS they will often complain of :

(a) An unexplained weight loss
(b) Persistent diarrhoea.
(c) Oral thrush, a white coating on the tongue and throat
(d) Swollen glands in the neck and / or armpit
(e) Discoloured areas on the skin (KAPOSI SARCOMA)
(f) A cough that won't go away
(g) Neurological symptoms
(h) Tuberculosis
(i) Skin infections
(j) Fungal infections.

Children experience similar symptoms. In addition, failure to thrive and repeated common infections as ear infection and pneumonia.

An AIDS patient to show above symtoms

It is important not to alarm people who are sick with these signs and symptoms. You have to explain to your patient that the illness can be caused by many things and only a Doctor can tell you the diagnosis.

3.3 MODES OF TRANSMISSION.

A counsellor has to remember that anybody can be infected by the HIV virus. It does not matter if a person is a male or female, young or old, educated or uneducated, urban or rural. Anybody can be hit and there is no reason to blame one another.

The virus is mostly found in:

(a) Semen – a man's sperms
(b) Fluids from a woman's vagina
(c) Blood and blood products (plasmic)

The virus is also found in other fluids as breast milk, tears, saliva but the role of these fluid in HIV transmission is not yet clear.

It is well documented that the leading modes of transmission are :

(a) Through sexual intercourse with an HIV infected person
(b) Through blood transfusion with infected blood
(c) From an HIV infected pregnant mother to her unborn child.

Minor modes of transmission are:

(a) Through contaminated syringes and needles
(b) Through contaminated razor blades or other skin-piercing Instruments.

It has to be stressed that the HIV virus is mainly passed from one person to another through unsafe sexual intercourse and some people are more at risk than others.

(a) Individuals who have multiple and/or unknown partners.
(b) Individuals having sexual transmitted diseases
(c) Individuals not using condoms
(d) Individuals receiving unscreened blood for transfusion
(e) Children born to HIV infected mothers
(f) Individuals with partners from any of above risk factors.

When planning your counselling session you have to be aware of the fact that most people cani imagine themselves infected with HIV, in particular when they feel strong and healthy. Many exp themselves to remain safe from the virus. It is one thing to see a Paster warning about AIDS a another thing to believe that these messages apply to us. That is a very common human attitude. remember to ask your patient what he or she knows about the virus and how it is transmitted. It w provide you the opportunity to explain that the transmission of the virus is associated with speci behaviour.

3.4 PRESENTING TRANSMISSION OF THE HIV VIRUS

It is extremely important to help people who have been infected with the HIV virus not to pass to others.

3.4.1 Preventing sexual transmission.

The only way to ensure not getting the virus through sex is:

Not having sexual relations at all, but that is not a realistic stand. Abstaining is very difficult for man people, in particular for the sexually active people. Some people might say:

(a) Abstaining will make me weak
(b) Abstaining will make me sick
(c) I feel to have sex with many women
(d) My husband is travelling a lot
(e) My wife is pregnant.

As a counsellor you need to deal with these statements in an honest and direct way. AIDS is real an people are dying from the disease. If your patient is having sex with others, he or she should be tol how to use a condom correctly. A new condom should be used every time there is sexual intercourse This helps to avoid contact with semen. Vaginal fluids and blood. You have to know how to instruc your patient on correct use of condom (please see appendix 7).

A condom can reduce the risk of infection but it can sometimes break so nobody can be 100% safe. But if correctly used it is an alternative.

Convincing people to change their behaviour when they feel healthy is very challenging for a counsellor. Many counsellors find it very difficult to talk with their patients about their sexual habits. It will be easier for you if you are aware of your own values about sex.

If you completely disagree with your patient's lifestyle, then it is better to hand over the case to another counsellor.

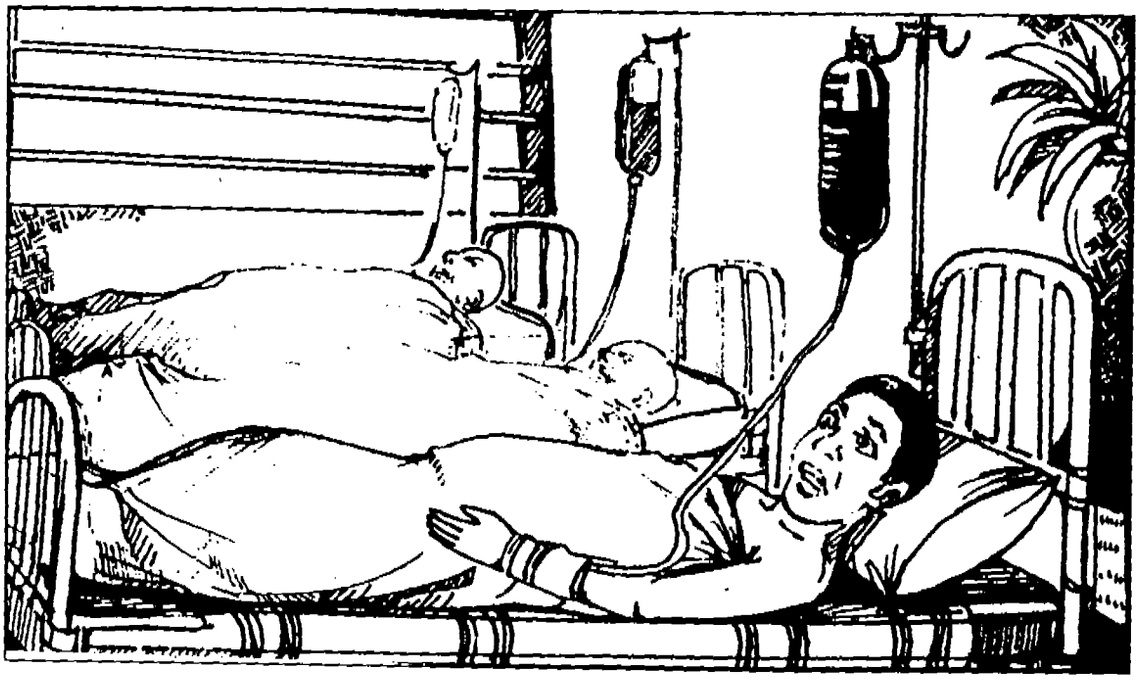
3.4.2 Preventing infection from mother to child.

The only way an infected woman can be sure of not passing the virus to her unborn child is to prevent pregnancy. But the issue is somehow complicated because it is very important to bear children. In societies where fulfilment in marriage is linked to have children, many women would still prefer to become pregnant. The counsellor can advise the HIV infected woman to contact a doctor before she gets pregnant or as soon as possible after she has become pregnant.

A mother breast feeding a baby

3.4.3. Preventing infection through blood transfusion and injection.

The only ways of not getting the HIV virus through infected blood are to make sure that blood received through blood transfusion has been tested for HIV and to make sure that syringes, needles, razor blades and other skin piercing instruments are only used once or sterilized after each use.



Patients receiving blood Transfussion

4. ROLE OF THE NACP IN COUNSELLING

The National AIDS Control Programme was established in 1988 in order to co-ordinate all AIDS control activities planned to reduce the incidence of HIV and AIDS morbidity and mortality. To date, HIV and AIDS has no cure and no vaccine. In this case counselling has become a very important strategy in the management of HIV/AIDS/STDs.

4.1 THE COUNSELLING AND SOCIAL SUPPORT UNIT

Among the seven technical Units of NACP, the counselling and Social support Unit is charged with the responsibility of co-ordinating all the counselling and social support services in Tanzania mainland. The overall objective is to ensure optimal quality of life of HIV and AIDS clients and their families.

4.2 The Unit is a resource in trying to help the establishment and expansion of the counselling and social support services throughout the country.

It is willing to help and support individuals, groups and organisations who are involved and interested in the field of counselling and social support.

So far the Unit has been establishing the counselling services in the hospitals. It has trained hospital based counsellors to provide counselling to HIV and AIDS patients in hospitals. All regions and 85 districts have trained counsellors.

4.3 The unit is also collaborating with other sectors (other than the health)and a number of non Governmental organisations who are in the field of counselling. This is done with an intention of mobilising more human and manpower resources which could as well assist in providing counselling and social support in the community. In order to make community counselling very effective, in collaboration with the NGOs the Unit intends to establish the Home based care (HBC)services throughout the country where self supportive activities will be established and care will be provided at patient's own home environment. The important element in this HBC system will be counselling of the individual patient, the family and the people around.

4.4 The Unit is also producing health learning materials such as calendars, posters and now the manual. It also intends to organise a number of in- depth skill oriented counselling workshops for the trained counsellors who are actually practising counselling, to provide them with enough skills to be able to provide confidentiality.

5. HIV/AIDS MANAGEMENT

HIV infection and AIDS is a social problem that affects the whole community.

There are some important facts to consider:

HIV/AIDS has

- No cure, but there are symptomatic treatment which can reduce symptoms and prolong life.
- No vaccine.

But we have one positive information we know that prevention is certain if the required behaviour change is adopted among individuals and communities.

Appropriate AIDS Management will weaken the impact of AIDS.

Two main objectives of AIDS Management are :

(a) To prevent and control further transmission of the HIV virus, and
(b) To provide optimal, human and supportive care for the patient and their relatives.

We have selected some of the most important components in AIDS Management namely:

(i) HIV testing
(ii) Counselling
(iii) Clinical care
(iv) Community Based Care.

In the following these four components will be described.

5.1 HIV TESTING.

A test is very important for the establishment and confirmation of the diagnosis of HIV infection of an individual. Laboratory tests are also important in the diagnosis of opportunistic infections and malignancies for which appropriate treatment can be provided in order to improve the quality of life.

When the HIV virus enters your body the body produces antibodies. But there is a period between the day the virus entered your body and the day your body started to produce the antibodies. This period is called the "window period" and it last for about 3 months.

It means that no HIV test can confirm that you are HIV positive – but your body is infected with the virus and you can transmit the virus to others without knowing that you are HIV positive.

In all cases of a positive test result, a second blood test will be performed in order to confirm the first test result (quality control).

There are many issues about HIV testing which are still being discussed. It might be interesting for you to examine the rationale behind and decide on the approach to deal with the issues.

(a) Should the patient give informed consent before testing?
(b) Should the patient be told about an HIV positive test?
(c) Who should/can break the bad news?
(d) How can one ensure confidentiality?
(e) Should people be tested before marriage? (Appendix 2)
(f) Should partner notification be mandatory?

More information given in Appendix 1 & 2

Many patients are not informed that their blood will be tested for HIV.
One of the reasons may be the heavy work load it would place on the staff in terms of sufficient pre-testing counselling.

As counsellor you might also meet patients claiming the right not to be informed. Others may say since I am going to die anyhow, I will take others with me.

You have to accept some element of confrontation and try your best to turn these attitudes into a positive approach.

5.2 COUNSELLING

In the context of AIDS Management the most important role of counselling will be to help people to take responsibility for preventing the spread of the virus within the families and communities and in this sense counselling means basic information on how:

(a) To inform your client/patient about his our her state in a compassionate way.
(b) To help your client/patient to understand what his or her state means
(c) To explain to client/patient how it influences his or her relationship with others
(d) To help your client/patient to accept and live constructively with his or her new situation.

5.2.1 Pre-conditions for successful counselling

Counselling techniques will vary between social groups according to resources available and traditional ways of how and whom to ask for help. But there are a number of universal pre-conditions of successful counselling, but their application is influenced by culture, traditions and beliefs. Most important is:

(a) Acceptance
Everyone who is counselled in connection with HIV infection and AIDS should always be and feel fully accepted irrespective of lifestyle, past behaviour, or other characteristic.

(b) Consistency
All basic information about infection, transmission, risk of infection and risk reduction must be consistent and accurate.

(c) Trust and confidentiality
Confidentiality is a basic principle of counselling and trust is a crucial element of the counsellor - client/patient relationship.

Whatever is discussed between the counsellor and the client/patient should remain as a private matter.

5.3 CLINICAL CARE

The clinical care to be provided depends on the signs and symptoms presented by the individual patient.

Together with blood testing, diagnosis is made on the basis of clinical signs and symptoms identified through a physical examination either in the home or at the hospital or clinic.

The physical examination can be made by a doctor, a nurse, a medical assistant and other medical trained personnel.

If you are a lay counsellor and have little medical knowledge, then always refer to some body more experienced. Dont try to diagnose or treat the patient yourself. It might speed up the patient developing AIDS.

The physical examination may include checking for among others:

- Clinical anaemia
- Nutrition status, weight
- Skin rashes
- Sores
- Herpes zoster
- Fever
- Oral thrush
- Painful cough
- Severe fatigue
- Genital ulcers
- The mental state. Is the patient in emotional balance, anxious or depressed?
- Fungal infections
- The state of mobility.

After confirming the signs and symptoms you have to make a care and treatment plan meeting the needs your patient have.

Before giving any drugs find out if the patient has already received treatment and what the treatment was. This is to avoid overdosing, resistance or counter acting the effect of drugs already taken.

Remember it is very important to provide each drug with clear instruction and to make sure the patient understand.

You also have to plan and organize follow up and evaluate:

(a) The effect of care and treatment provided
(b) Side effect if any
(c) If the care and treatment should be continued or changed
(d) Or if the patient should be recommended for further investigation.

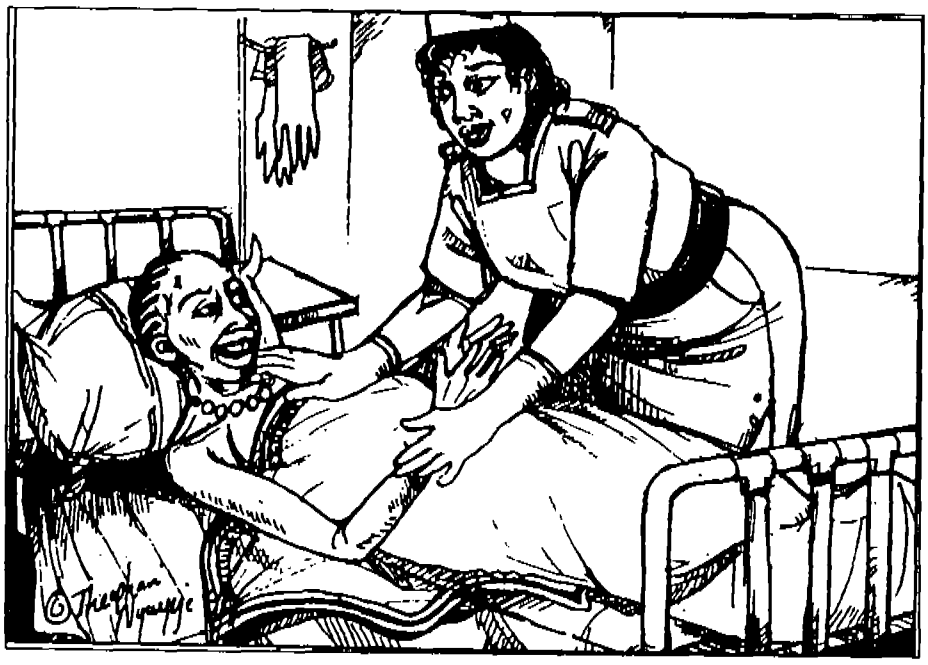
Many painful symptoms as chronic diarrhoea, painful cough, and thrush, severe fatigue may create emotional distress. That indicates provision of supportive counselling and your patient might need to know how to get in contact with you when needed.

5.3.1 Personal precautions

It is known that many health professionals fear to contract HIV infection when caring for the patient. Keep in mind that transmission of HIV only occurs through contact with blood and other body fluids of infected patients. Safety procedures minimise the risk of staff being exposed to the virus in the course of their work and, remember the virus won't survive long outside the body. Common soap, water and boiling will kill the virus and if you follow few simple working rules you can feel safe.

For example:

(a) Use disposable gloves to take blood specimens from all patients and those suspected to be HIV positive.
(b) Use disposable gloves if your patient has open sores or lesions.
(c) Only use syringes and needles once and place them in a special container for sharp objecti tives after use.
(d) Slashes of blood have to be washed away immediately with whatever antiseptic available.
(e) Soiled linen has to be soaked in hypochlorite for 2 hours before being sent to the laundry.
(f) Contact with eating utensils does not give you the virus
(g) Shaking hands, touching and other social contact will not infect you.



If you follow these rules you are provided with a maximum degree of protection, but continue to seek accepted and approved knowledge about your working area. Continue to educate yourselves.

5.3.2 Information about treatment

As a counsellor you have to explain to your patient that:

(a) There is no cure for AIDS anywhere in the world either through traditional treatment or modern medicine.
(b) The only way people can protect themselves is to avoid contact with the virus that causes AIDS.

In the past many people have claimed to have a cure. But you have to warn your patients against false claims. Many people have already been disappointed and lost their money too.

Many drugs against the HIV virus are being tested for safety and effectiveness and some of these will be available in the next few years.

The same applies for a vaccine. Researchers all over the world are working on a vaccine and one day it will be available.

(c) Finally remind your patient that prevention is better than treatment and knowledge is better than ignorance. With the knowledge you gain, there are things you can do to prevent transmission.

5.4 COMMUNITY BASED CARE

Community Based Care is a health service system built upon Community Participation and intersectoral collaboration. AIDS affects community life. Men and women are infected in equal numbers and the disease affects all socio-economic groups. The presence of the disease influences the dynamic and the function of the individual family and becomes part of the family's daily life.

The key issue in Community Based Care is to integrate prevention, control and care strategies as part of family responsibilities with support from the community, in terms of a Home-Based-Care Programme. A Home-Based-Care Programme offers health services in the home environment of the person with HIV infection and AIDS through regular visits. The programme can be expanded to include self supportive activities to meet the daily basic needs of the family.

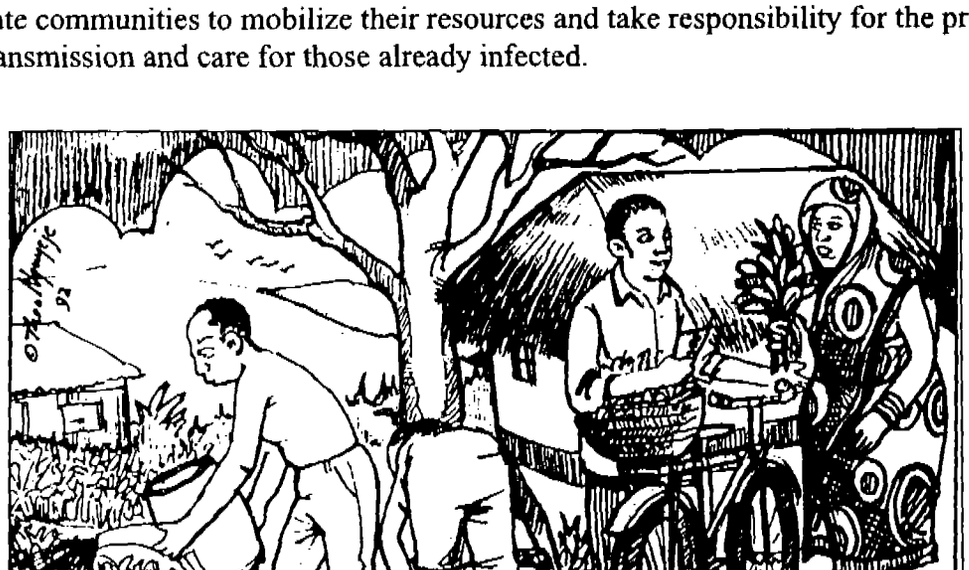
What is a community?
The most common type of a community is the village known by:

(a) The presence of a multisectoral leadership to which members are loyal
(b) Experience in consensus decision making, and
(c) A sense of belonging to the whole.

Community action is based on the understanding that, unless each member makes appropriate decisions for themselves and the community the threat of AIDS destroying communities will linger on.

In the perspective of AIDS management the goal is:

- To motivate communities to mobilize their resources and take responsibility for the prevention of HIV transmission and care for those already infected.



Villagers working on a small poultry farm or amaranth to sell so as to raise money for the patient.

Try to stimulate relevant community based activities within the frame we have described for you.

6. COUNSELLING

6.1 INTRODUCTION

Through the counselling process you provide your client with the necessary information and advice in order to help him or her to cope with his or her situation.

It is more than only conversation, a chat with a friend. It is a process taking place through regular planned meetings with your client.

Counselling does not mean that you have to be very skilled and professional with a long training on counselling skills. No, most of the counselling which is practised is done by people who have developed their skills through experience from real life, through handling human problems in all aspects of life, reading and sharing ideas with others. These counsellors are extremely valuable for our work.

Counselling also does not mean "to tell" only. To inform a person that he or she has HIV and AIDS takes you a very short time (1 minute) and does not help the client at all. To counsel can take you hours and requires:

(a) **Knowledge :** As a counsellor you have to be very knowledgeable about AIDS, but you will learn it with time.

(b) **Skills:** What you learn in theory about how to establish a positive relationship with your client and how to do counselling has to be practised. You start with role plays and slowly you see the clients. You will only learn through experience, some supervision and expert advise from time to time.

(c) **Attitude:** A positive attitude is very important. You have to be understanding, interested in your client, show that you are concerned and care. And often you have to leave your own values and beliefs behind.

Important Elements of counselling.

1. The client must have a disturbing problem and willing to talk about it.
2. The counsellor must have accurate information and working advice to share with the client regarding the problem.
3. The client must accept and use the information and advice given.
4. Counselling is a process and not a finished product.
5. The problem is either solvable or not.

Counselling

Decision making

PROBLEM SOLUTION	COPING WITH	DEFERMENT
Solvables: - Seeking medical help - Buying another bicycle - Re-sitting an exam. - Managing time etc., etc.	Unsolvables: - Death - Incurable disease - Loss of fiancee - Ugliness etc., etc.	Solvables and Unsolvables.

Who Needs Counselling?

Any individual with a disturbing problem that is physical, social, spiritual, mental or moral.

The Counselling Place

This can be anywhere where there are no disturbances, such as noise, heavy traffic of passers-by, eaves-dropping, telephone ringings, dusty and littered rooms, lights shining directly into the client's eyes and the like. In short, a counselling place must be private, comfortable, quite and assuring CONFIDENTIALITY.

When to Counsel

At any convenient time clients come to counsellors with disturbing problems AND DURING CRISES where prompt action is a must always.

Who is a Counsellor?

A counsellor is a mature person who cares and is interested in helping others in need; who is knowledgeable about counselling; and who has positive regard for fellow human beings, i.e. who is accepting, understanding, accessible trustworthy and who keeps the confidences of the client.

But Why Counsel Anyone in Need?

In order to bring him/her back to the state of balance where/she operated before the problem jolted him/her.

TYPES OF COUNSELLING.

Counselling falls under two major categories; INDIVIDUAL and GROUP Counselling.

I: Individual Counselling

A: This is a one-to-one helping relationship in which the counsellor helps the client to either solve or cope with the letter's problem.

B: Features of this category of counselling include:

1. The client comes, or is referral to the counsellor for help. Sometimes the counsellor goes to the client to help him/her in his/her environment.
2. The client may be:
   (a) Mentally capable – able to talk rationally
   (b) Mentally distraught – irrational
   (c) An adult – with life experience
   (d) A youth – with less life experience
   (e) A child – inexperienced.
3. Counselling may take one or several counselling interviews/sessions.
4. The counselling relationship terminates:
   (a) When a solution to the problem has been reached.
   (b) When the counsellor refers the clients to another professional helper.
5. Counselling rendered is therapeutic/curative.

C: Types of (therapeutic/curative) Individual Counselling include:

1. Educational Counselling, e.g. problems of subject choice, lack of concentration, lack of adjustment to new school, etc.
2. Vocational Counselling, e.g. choice of a career.
3. Personal Counselling on physical, social, moral religions and emotional problems.
4. Crisis Counselling upon loss, death, illness, divorce and all kinds of traumatic experience.

II: Group Counselling

A: Group Counselling is a one-to-group helping relationship in which the counsellors work with the group in seeking a solution to their common problems.

B: Features of Group Counselling include:

1. Clients must have a common problem
2. Members of the group must be mature and mentally sound to be able to talk about and tackle their common problem.
3. Psychotics and pyschopaths should be removed from the group lest they disrupt meaningful discussions.
4. Monopolists and bullies should be given individual counselling to enable them respect other members' views before they are allowed to join the group sessions.
5. The counsellor normally goes to the clients; but with smaller groups such as couples, families, students, etc., clients normally to the counsellor for help.
6. Counselling is either TRADITIONAL or INNOVATIVE
   (a) In Traditional Group Counselling:
   (i) Groups are smaller, i.e. normally not less than 6 or more than 16 members.
   (ii) Clients come to the counsellor, e.g., to the Youth Pastor, at Church, to the School counsellor at school, etc.
7. Group Counselling is primarily preventive and supportive. It may also be therapeutic/curative.

III: CONCLUSION

Individual and Group Counselling are the two major categories of counselling. Each category has several types of counselling. For example, counselling an individual with a physical problem is individual counselling, whereas community counselling to empower communities to prevent the spread of HIV infection and to support those in the communities already affected by HIV infection, is Group Counselling. Hospital-based counsellors will do follow-up counselling where families, etc. may be counselled using Group Counselling methods.

6.2 AIDS COUNSELLING

AIDS counselling is a special area in counselling which requires more in-depth knowledge in this field.

Besides the knowledge about AIDS it requires the same counselling techniques which you apply to other clients.

The stigma.
HIV infected people or AIDS patients are often stigmatised in society. Stigmatised means being brand marked. Stigmatised people are often rejected by the community. Since HIV/AIDS is mainly transmitted through sexual contact people associate being infected with bad behaviour.

The stigma, however, has become less because AIDS has become a more common disease in Tanzania which has affected all areas.

Fear of the community.
If someone has cancer the community will sympathise with the patient and do everything to make the patient feel comfortable.

In cases of HIV/AIDS the reaction of the community is often different. People who care for someone being infected are often afraid of being infected themselves through close contact with the patient.

Good counselling which includes giving lost of information will always reduce the fear and make life easier for the patient and for the care taker.

AIDS Counselling means:

(a) Help your client to understand (knowledge) what HIV and AIDS means.
(b) Help your client how to cope with it.
(c) In cases of AIDS help your patient to die peacefully and his or her relatives and caretakers to cope with it.

What does confidentiality means here:

(a) Don't inform anybody about the client's result before you talk to him or her.
(b) If your client does not want you to inform anybody (even his or her partner) you should not do so. Respect your client's wish otherwise you break the positive's relationship.

6.3 WHO CAN PROVIDE COUNSELLING

We all more or less have some experience as counsellors and we have to rely on professionals as lay counsellors depending on the different circumstances. As counsellors some might need additional training in the needed skills but we believe it is very important to identify and mobilize resources in communities in order to promote behaviour change.

It is also crucial to mobilize local people knowing the local language, cultural aspects and beliefs, people with a special attitude and personality committed to patient care and community counselling and education. In fact, it could be anyone who from heart cares, who is trusted, respected and having a role of acceptable authority. For examples:

- Community Leaders
- Health Personnel
- Traditional Healers
- Religious Leaders
- Social Workers
- Mass Media
- School Teachers
- HIV infected
- And other volunteers

More than that a good counsellor should keep the confidences of any client, except he/she gets the permission from the client or is asked by him to talk to a certain person. For this an agreement has to be signed by the client (see Monitoring Instruments).

Otherwise confidences only can be shared with professionals in order to assist the client better, e.g. supervision.

Confidentiality is always important with any patient, but since AIDS patients are more stigmatised, confidentiality is even more crucial.

6.4 COMMUNICATION SKILLS

In order to be an effective counsellor, we need to have good communication skills. Communication skills enable the person to share his or her problems and helping him/her to cope with them.

Four major communication skills are:

(1) Listening
(2) Checking you have understood what the person has said
(3) Asking questions
(4) Answering questions

1. LISTENING.

The first and perhaps the most important skill is to be able to be a GOOD LISTENER.

We have to be able to listen well in order that we can try to understand.

HOW do we listen well?

We show that we are listening by using a number of techniques

(a) We pay ATTENTION to the person we are counselling. We use our own body language to show that we are paying attention. It is helpful to

R - be Relaxed
O - Open
L - to Lean forward towards the person
E - to keep Eye contact with the person
S - Sit near the person

We can encourage a person to talk by nodding or responding by facial expression to what is being said.

We should not yawn, fidget, look around or out of the window or do any other things which might indicate boredom or impatience.

2. CHECKING WE HAVE UNDERSTOOD WHAT WE HAVE LISTENED TO

It is important to check that we have understood what the person has told us. Why ?

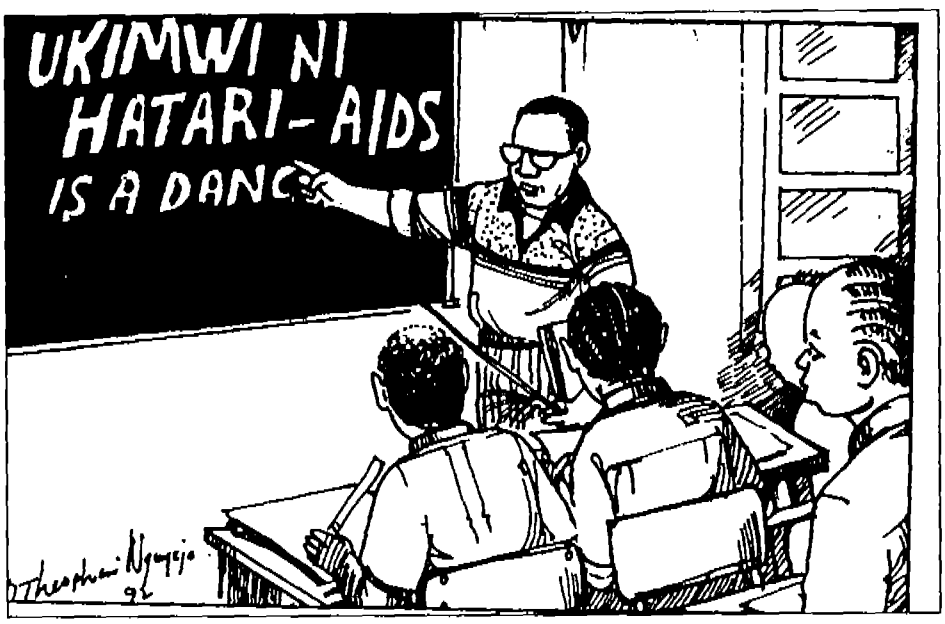
1) It lets the person know we have been listening carefully.
2) It lets the person know we are trying to understand
3) It gives an opportunity for the person to think again about the problem, and may help him/her think about how to cope with the problem.

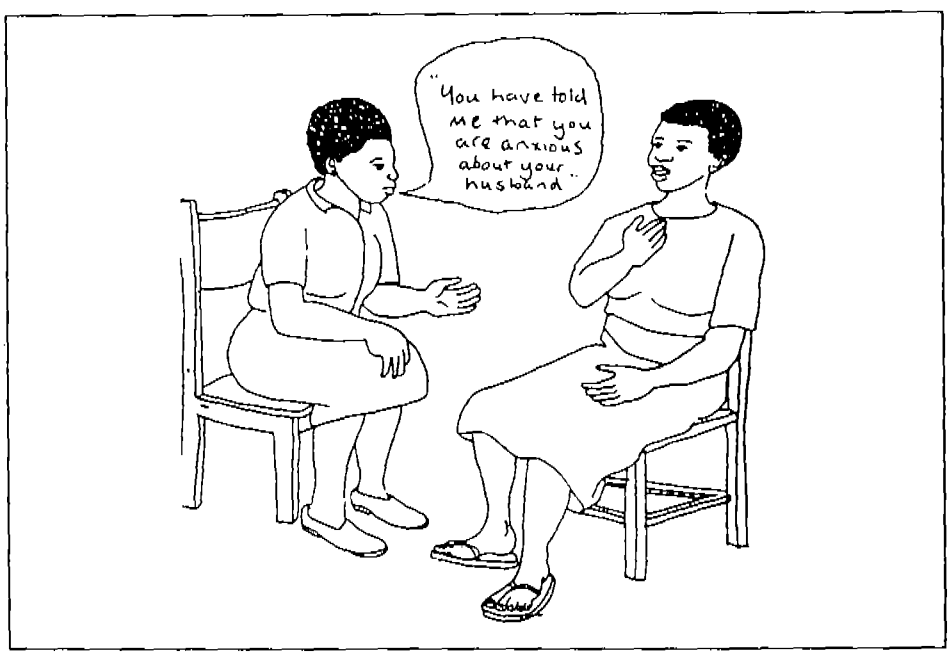
How to do this?

1. We check we have understood what the person has told us by REPEATING BACK what the person has told us using words like; You have told me that .....

   SUMMARISING what the person has told us, using words like "You have said that you are worried about three things in particular ....."

2. We check that we have understood what the person was feeling by IDENTIFYING THE .. of the person, using words like "It seems that you are very worried about this".





b) We listen to and try to understand the person's NON-VERBAL COMMUNICATION – body language.

We should be able to try to guess what the person is feeling from observing his/her face and movements.

c) We use SILENCE constructively.
Sometimes a person may stop talking. She/he may be thinking about the situation. Do not hurry to talk.

It is very important not to interrupt the person when she/he is talking.

d) We listen and try to understand what the person is saying verbally. We need to be able to remember accurately what the person has told us.

A good listener listens with empathy and tries to understand what the person is saying , expressing verbally and non-verbally and what the person is feelings.

The next skill is to check that we have understood properly.

3. ASKING QUESTIONS:

We ask questions in counselling

1) To help the person explore his/her problem(s) more fully.
2) To help the person think more about their situation and perhaps find a way of coping with their problems.
3) To help the person explain what she/he already knows or understands about the situation i.e. facts about HIV.
4) To show that we are trying to understand the person and the problems she/he is facing.
5) Questions ca also help the counselling session to move at the person's own pace and enable dialogue between the counsellor and the person who is seeking help.
6) Questions can help to priorities problems and thus help to focus the counselling session.

HOW DO WE ASK QUESTIONS?

There are two main kinds of questions.

a) Closed Questions
These questions usually receive no more than a "yes" or "no" answer and are generally very specific e.g. " Are you married?". "Yes"

This type of question does not invite the person to talk more.

Sometimes closed questions can seem very threatening if a person is vulnerable. It can sound as if the counsellor is interrogating the person.

We try to avoid this type of questions when counselling.

b) Open-ended Questions - these are questions which invite a person to talk and to explain.

E.G. "Can you tell me about……?
"What do you want to happen…..?
"What worries you most?

Questions like this permit the person to choose how to respond and helps him/her examine the situation more clearly.

POINTS TO REMEMBER WHEN ASKING QUESTIONS

1) Good questioning uses very simple open-ended questions.
2) It is confusing to ask a number or questions at once.

An example of asking question that is not helpful is:

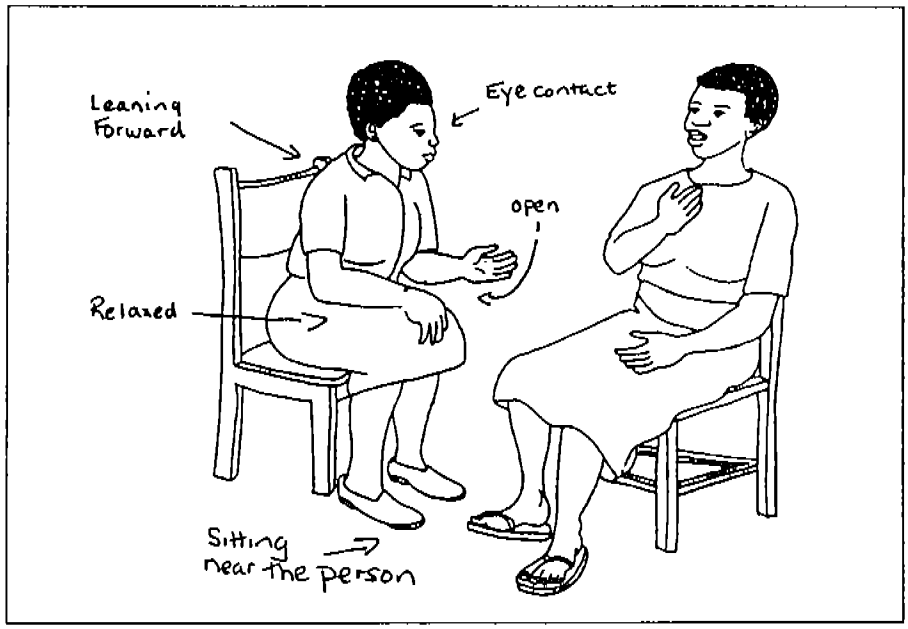
Counsellor: What do you know about HIV infection? Do you know how HIV is transmitted?" Do you know about "positive living?".

Person (confused) – "I do not know"

If the counsellor has asked one of these questions at a time the person might have been able to answer.

3) After asking a question and receiving an answer use some of the key words the person used in his/her answer to frame the next question.

For example:
Person : "I feel so Worried"
Counsellor: "What worries you most"?
Person: "I am most worried about my husband being upset"
Counsellor: " What do you think would upset him most?".



4. ANSWERING QUESTIONS AND PROVIDING INFORMATION ABOUT HIV INFECTION.

People may ask counsellors questions for various reasons. For example they may ask for advice, for information, for the counsellors opinion.

As counsellors, we have to use particular skills to answer these questions.

POINTS TO REMEMBER WHEN ANSWERING QUESTIONS.

1. Behind most questions is a story or a problem.

   The counsellor should always consider why the person is asking this question

2. Counsellors can give people information.

   For example: - information about HIV and AIDS

   Information allows people to make their own informed choices.
   Counsellors try not to give advice.

"No, mosquitoes do not transmit HIV"

d) Talking about Implications of Knowledge

For example:

"Knowing how the virus is transmitted, how will you protect yourself and others in the future from being infected?"

Knowing how the virus is transmitted, do you think you might be at risk of being infected?"

7. MAJOR TYPES OF AIDS COUNSELLING

7.1 PRE-TEST COUNSELLING

Pre-test counselling is the counselling provided before the test is done.

According to the recommendations of the Ministry of Health (see Appendix 1) people should be counselled before testing if counselling facilities are available. Counsellors should be aware of the current guidelines for HIV-testing practices.

TO WHOM CAN WE PROVIDE PRE-TEST COUNSELLING

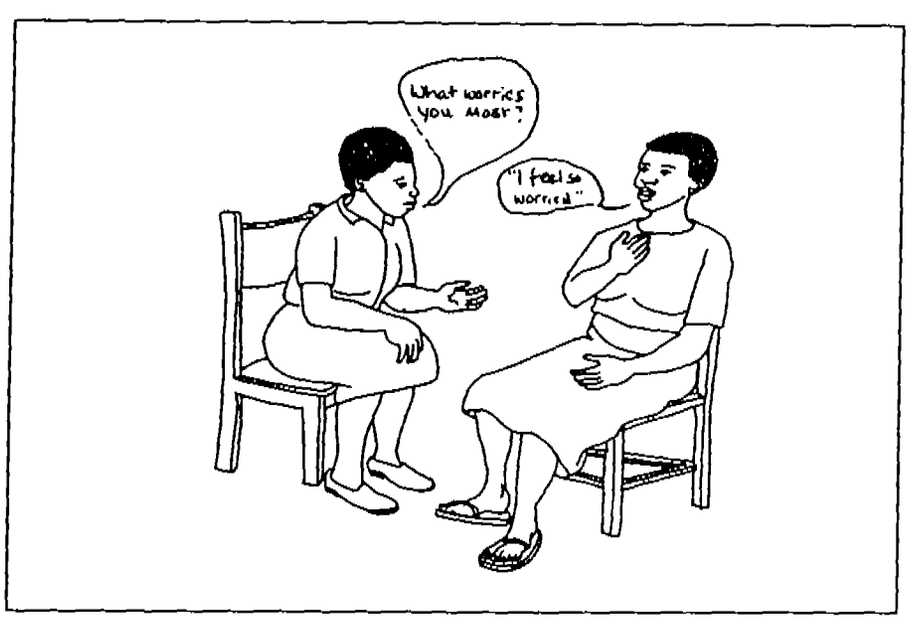
(a) People who are worried about being infected of having AIDS
(b) Their partners
(c) People who donate blood
(d) People who have symptoms of the infection/disease
(e) People who are tested before surgery
(f) People who have to be tested before going abroad
(g) People who want to get married
(h) Others.

They DO NOT say "You should"
"You must"
"I would advise you to..."
as this does not help the person decide for him/herself what to do

3. Before giving information check carefully by asking open-ended questions what the person alread knows.
4. Only give accurate information – Be honest. It is all right to say you do not know.
5. For some questions there are no answers.

For example – "How long will I live?"

6. Answer questions using simple clear language. Complicated medical language can confuse people. Avoid using jargon.
7. When you give information, check that the person has understood you by asking open-ended questions again.



Counsellor asks question

To find out what the person already Knows.

4) When we are counselling in TASO we often ask questions about peoples knowledge about HIV and AIDS. The following sequence can guide questioning.

a) Questions about Knowledge about HIV
For example: "what do you understand about HIV and AIDS?
"How is the virus passed on to other people?
"what do you know about the HIV antibody test?"

b) Assessing the Source of Knowledge
For example:
"How did you learn about HIV?"
"How did you find out about this clinic?"

c) Correcting misinformation
For example:
"No it is not a test for AIDS"

WHAT DOES PRE-TEST COUNSELLING INVOLVE

A. Establishing a positive relationship with your client.

B. Questions

(i) Find out WHY the person wants to do the test and WHO has asked for it:
- The client
- The doctor

(ii) Find out WHAT behaviour and symptoms are of concern to client
(iii) Enquire about the history of the client going back to the previous 5 years.
- Sexual history (more than one partner, any STDs and use of condom).
- Any blood transfusion
- Any exposure to skin piercing object (e.g. by local "Doctor")

(iv) What does the client know about the test
(v) Does the client consider the possibility of a positive result and how would he or she
(vi) What does the client know about HIV and AIDS and ways of transmission.
(vii) Who could provide emotional and social support (family, partner(s), friends and oth

C. Giving basic information on HIV and AIDS and testing:

(i) HIV is not AIDS; explain the difference
(ii) The meaning of an HIV positive result
(iii) What kind of tests can be done;
- ELISA
- WESTERN BLOT
- RAPID TESTS

And how much time they take.

(iv) Explain "window period" meaning the time between infection with the virus and the produ of the antibodies, which can take up to the months and in some cases even longer.
(v) Explain that in some cases technical errors might occur which result into false positiv false negative results.

D. In case the client agrees to do the test, a testing form should be given to him or her an appointment for the post-test counselling. Ensure an informed consent is given b client. Pre- test counselling should always have a preventive character and motivate chan behaviour.

Individual pre-test counselling takes time depending on the client's problem.

To do the counselling you need a bit of privacy, not necessarily your own office, but a place where can talk to your client without too much disturbance.

CASES

NO. 1 PETER

Peter is a 21 years old University student who is extremely worried. Since he heard about AIDS he has never had any more girl friends.

Recently, however, he travelled to Dodoma, went to a Disco, got a drunk and was "taken away" by a girl whom he did not know. Although he was quite drunk he still remembered use a condom.

Since Peter came back from Dodoma he has been having sleepless nights and always think about AIDS. He is so much afraid of being HIV-infected.

Management

First try to establish a positive relationship with Peter, a relationship of trust and confidence.

It seems unlikely that Peter is HIV-infected although we are not sure.

We don't know when Peter first heard about AIDS and stopped having girl friends and what happen before that time.

We also don't know if someone drunk can use a condom properly.

A test might not be reliable, because Peter's trip to Dodoma was only last week and he might still be i the window period.
So a lot of questions have to be asked and a lot of basic information has to given to Peter. His anxiet might be reduced by the information and reassurance (but no false hope).

If the anxiety is still persistent, he might be referred to a doctor for some treatment.

After a long session of pre-test counselling Peter is ready to be tested. Peter is given some booklet with basic information on AIDS and an appointment one week later. Peter's results turn out to be HIV negative.

No. 2 JUMA

Juma is 30 years old and lives in Zaire. His father is a Zairian and his mother a Tanzanian. Most of his life Juma lived in Zaire but came regularly to Tanzania to visit his relatives here.

He come back in March this year, and this time all his relatives behaved very different, it seems nobody wants to have him around without any obvious reason. He goes to Tabora and finds his usually friendly relatives are not very welcoming. When talking to a missionary nearby he hears that all his relatives believe that he has AIDS and don't want to be infected by him.

Some even believe that someone jealous of him has bewitched him, because his mother, unlike all her other siblings, became rich in Zaire.

He asks an aunt who works at Tabora Hospital to test him and when the result are out the aunt tells him that he does not have AIDS but refuses to show him the results. Juma decides to come back to Dar es Salaam and on arrival in Dar es Salaam his relatives make it very clear that he cannot stay at their house. He hears that they have given away the bed he slept on. When Juma comes he is very depressed.

Management.

Juma needs 'a shoulder to lean at', someone who does not reject him, who understands him and talks to him. So establish a positive relationship first, make Juma feel comfortable and trust you. He has gone through a very difficult time.

Juma looks healthy although he admits to have had quite a few girl friends during the last years and

always practised unprotected sex. So Juma is at risk of being infected. Juma does not know much about AIDS and needs a lot of basic information.

After a long session of pre-test counselling, Juma is ready to be tested. Before going off that day he is told WHERE and WHEN to find the counsellor in case he has a crisis and wants to talk. He is also told that there is a group of people who are HIV positive or who have lost a relative from AIDS, who meet every Friday and that he could always go to the meeting. He gets an appointment one week later. Juma's test results (including Western Blot) turn out to be positive.

No. 3 MAMA ROSE

Mama Rose is admitted on the paediatric ward with her daughter Rose who is sick. Rose is 4 years old and does not walk properly due to some malfunctions of her brain. She always has fever, different infections and is an unhealthy child. Mama Rose is a nurse who works in Songea and her husband died 2 years ago of TB. Besides Rose, there are 2 older children and twins who are 2 years old and healthy. Mama Rose herself is not feeling well. She always complains of malaria, fever and is very weak. Since Rose is always sick, Mama Rose is extremely exhausted, she has tried every way to help Rose but has lost hope.

When she comes to see you she is depressed, and tired of seeing another 'expert' who asks again the same questions.

Management

Mama Rose needs someone with whom she can feel comfortable, someone to express her emotions. She is physically and emotionally tired. So after establishing a positive relationship with Mama Rose, give her time to express her emotions, show her that you sympathise with her, you are concerned and you care. Slowly, you talk about HIV and Rose's symptoms suggest that it could be HIV. Being a nurse she always suspected Rose to have AIDS and she also remembered that some people said her husband had died of AIDS.

After a long session of pre-test counselling Mama Rose agrees that she and Rose are tested. She is told that she can see you anytime to have a chat before the 'real appointment' next week.

The results shows Mama Rose to be HIV positive and Rose is HIV negative.

NO. 4 MZEE FADHILI

Mzee Fadhili is a 50 year old carpenter who lives with his two wives and 12 children in Mwembe Chai. Since he developed TB he could not work anymore and the family had problems to survive.

While being admitted in the ward the HIV test was taken without his knowledge and now he is referred to you for breaking the news of being HIV positive. When he comes to see you he believes that you are another specialist in the hospital and is happy to meet you.

Management

The management of Mzee Fadhili is a bit difficult. First you don't know where to start, being annoye with the physician who referred Mzee Fadhili to you. 'Does he know about our new guidelines' yo ask yourself. You feel like phoning him immediately, telling him that he should 'do the job himself' but then you look at Mzee Fadhili and you just try. You tell him that he is recovering very well fron TB and after finishing the injections he has to go on for a whole year to take drugs. You ask him a lo about his family, his job and establish a good relationship with him.

Slowly, you explain him that TB could also be a symptom of the so called 'new diseases' and you find yourself already in the pre-test counselling.

Mzee Fadhili is still relaxed and listening to you, happy that an 'expert' is so much concerned with him and takes so much time for his problems.

He is immediately willing to be tested by saying 'everything is in God's hands!'.

His first wife is of his age and they have eleven children. The second one is eighteen years old and delivered a baby boy three months ago. He now spends all of his time with the second wife.

The session with Mzee Fadhili takes very long but also you enjoy talking to him, he is such a pleasant old man! Before going off you tell him to see you again after one week.

The repeated test of Mzee Fadhili turns out to be positive again.

7.2 POST-TEST COUNSELLING

Post-test counselling is the counselling which is done when the test results are out.

It is not advisable to give the test result through the telephone or before a weekend, when the patient cannot be followed up easily and get support.

7.2.1 Counselling someone who is HIV negative.

Usually you are as much encouraged and happy as the client and you should share the client's happiness.

Repeat basic information again.

Let the client explain in his own words how to prevent infection (and correct misconceptions if any).

In case the client is still in the window period, make another appointment after 3 months to repeat the test.

Inform the client when you are available (or your colleague) in case he or she wants to see you again and talk to you.

Give booklets on AIDS if available, to strengthen the knowledge of the client.

7.2.2 Counselling someone who is HIV positive.

Although you have talked with your client about the possibility of being HIV infected there is al the hope that he or she is not infected and usually people are not prepared for HIV positive resu

The news will be a shock for the client and if someone is under shock he or she is emotionally paral So don't try to convince your client that it is no problem (false hope) or try to give a lot of inform because someone under shock is not listening to you.

The best attitude is to be quiet and only answer questions which the client raises. Otherwise be supportive in your attitude. Allow the client to express his or her emotions. Let him or her cry if he or she wants to.

Give the client time to 'digest' this shocking news you should recognize the signs of depression and suicide tendency. Make sure that the client reaches home safely. Make the client identify people to seek help when in need. Make sure that you make an appointment for a follow up visit. Tell your client WHEN and WHERE you will be available in case he or she has to see you urgently.

CASES

No. 1 Back to PETER again (see page No. 27)

Peter's result is HIV negative, he is not infected and he is very happy about it and you as well. So spend a few minutes just sharing your happiness. You have talked with Peter about the window period before and you remind him now and might arrange another visit after 3 months to do a repeated test, if Peter wishes. But at the same time you welcome him to your office, whenever he has a question or a problem and inform him what is the best time to see you.

You repeat basic information on AIDS briefly again. Let Peter say in his own words how he want to stay healthy (uninfected).

No. 2 Back to JUMA again (see page No. 28)

Juma is extremely anxious when he comes to see you as if you are the one who decides about life and his death. After greeting him inform him that the results are out and that he is HIV positive. For Juma this seems to be the end of the world and you listen to him and comfort him by your presence. You ask him how he wants to go home now and give him an appointment to come and see you again after a few days. Tell him WHEN and WHERE you are available in case of severe stress. In case he has questions answer them. In that the result has been confirmed by Western Blot.

No. 3 Back to MAMA ROSE again (see page No. 29).

When Mama Rose comes back again she is not very anxious. It seem she has gone through such difficult periods that not much worse can happen. She is touched to hear that she is HIV infected which also might confirm that her husband died of AIDS. She feels guilty, thinking that she might have contracted the infection while working on the maternity ward and passed it on to her husband.

She is, however, very relieved to hear that Rose does not have AIDS, but still Rose remains sick and no real treatment seems to be forthcoming. After spending a long time with Mama Rose, you tell her to see you again next week but also in between you are available.

During all the session Rose is weak and quiet, always being in her mothers arms. You give Rose something to play with while you talk to her mother.

No. 4 Back to MZEE FADHILI again (see page No. 27)

When Mzee Fadhili comes to see you after a week he looks as happy as he did when you met him fi

After greeting him you inform him that the test results are out and that he is HIV infected. You a shocked by his reaction, expecting that he would be emotionally touched, while he only comments: it is all God's will!' You enquire more about his two wives and he tells you that his second wife is n very healthy since she delivered but feels it is normal ' she is still so young!'. Also the three montl old boy does not grow well and has a lot of problems.

The first wife seems to be very healthy but they are in bad contact since he took a second wife. H first wife Mama Mwajuma did not want to see Mama Furaha moved into the same house. Whe Mama Furaha moved into the house six months ago, Mama Mwajuma started going daily to a certai witch-doctor at Shimo la Udongo and since then Mama Furaha and now Furaha are oftenly sick Mzee Fadhili could not send Mama Mwajuma out of their house, also could not afford to rent anothe place for Mama Furaha, especially now since he became sick and lack of harmony in the house.

After bringing his second wife into the house, Mama Mwajuma threatened him that 'he will have tc pay for it' and then he developed TB.

When you ask him if she has bewitched him and his new family he just smiles and tells you 'you know how things go here' and you both laugh about it.

Before Mzee Fadhili leaves, you to talk a bit about the chances of his second wife, his baby and also his first wife being infected and if he could bring them next time for discussion. He tells you that he will try but it is difficult to bring them both.

When you ask him if he has started sexual relationship with Mama Furaha again, he tells you that is not the custom to do so when the child is only three months old, and he does not have any other partner at the moment. Again, this was a very long session with Mzee Fadhili but you like it as well. You tell him to see you again after two weeks but leaves free to see you anytime in between.

7.3 FOLLOW UP COUNSELLING/ SUPPORTIVE COUNSELLING

Supportive counselling is the long term support for an HIV infected person or an AIDS patient.

It involves seeing a patient on a regular basis which can take a short time but also be over the years. The patient will come to you with different problems at different stages of the infection.

The problems can be:

(a) **Emotional and Psychological**
(the patient gets anxious about his or her future. The patient gets depressed or even wants to die).

(b) **Medical**
(Patient gets sick).

(c) **Family and social**
(the patient has problems with his or her family members, at work or with friends and neighbours).

(d) **Spiritual**
(the patient is looking for explanation why he or she got infected).

(e) **Economical**
(the patient might not have enough money for food, medicines and other important things).

(f) **Political**
(the patient wants to travel and is not allowed due to his infection).

As a Counsellor you have to be able to help the patient cope with the different problems. This, however, does not mean that you can solve them all.

For the **EMOTIONAL** and **PSYCHOLOGICAL PROBLEMS** you could try to find out what is the problem. Is the patient finding it difficult to cope with his or her situation? Is the patient still denying, afraid to die or has other complaints?

For the **MEDICAL PROBLEMS** you can always advise the patient to find a way to cope with it. Some guidance and advice might be helpful but don't always tell him or her your solutions. What is good for you might not be good for the patient./

For the **FAMILY AND SICIAL PROBLEMS** you can help the patient to find a way to cope with it. Some guidance and advice might be helpful but don't always tell him or her your solutions. What is good for you might not be good for the patient.

For the **SPIRITUAL PROBLEMS** you could send the patient to a spiritual leader according to his or her spiritual and cultural background.

For **ECONOMIC PROBLEMS** you could inform them about institutions (e.g. Social Welfare, Churches etc.) who are willing to assist. You might refer to self-help groups if available.

For **POLITICAL PROBLEMS** you could refer to the institutions concerned, (e.g. ministries).

For severe anxiety and depression you might refer to a doctor or even a psychiatrist. Always keep in mind that if someone is depressed he or she might commit suicide and if you don't feel experienced or comfortable enough to deal with a suicidal patient **DON'T TRY,** refer to someone who knows how to do it.

With normal anxiety and the patient feeling 'down' you should always try to assist yourself , sometimes you may need some supervision or expect advice. You may advise the patient to see a support group, where people with similar problems meet regularly. You could suggest literature (which you have read before) such as booklets and videos which you feel are helpful and available.

The patient always needs a lot of encouragement, support, guidance and sometimes a new (different) perspective to see that life goes on and still has a meaning.

So as a counsellor you should know with whom you can collaborate.

7.4 PARTNER NOTIFICATION

Clients are advised to inform their sex partners about their HIV-Serostatus and if they cannot do it on their own, the counsellor will invite the partner and inform him/her, provided the client has given a written consent to the counsellor before. Otherwise the counsellor will break confidentiality.

In Tanzania Research has shown that it is much easier for infected men to inform their partners. of women do not abandon their partners and are the main caretakers once the men gets sick.

The situation for women for women has often shown to be different because, women are in most hesitant to inform their partners because of fear of abandonment and being blamed for causir problem.

It needs a sensitive and experienced counsellor to talk about partner notification and to deal with preventive reasons however, (preventing new infections and re-infections) it is important to talk a it with the client.

The decision however if and how to inform the client should be role responsibility of the client.

CASES

No. 1 Back to PETER again (see page No. 32)

Peter comes back again after 3 months in order to do the test again, but he is less anxious about be HIV infected.

You discuss with him how he is doing and repeat information of prevention before you do the test. is a bit similar to a pre-test counselling session.

Peter's repeated test turns out to be negative and after a week you inform Peter about it. Befc leaving you encourage him to be careful and prevent himself and again repeat when and where y will be available and welcome.

No. 2 Back to JUMA again (see Page....)

Juma needs a lot of long-term support. After having 'digested' the bad news, Juma needs a lot c guidance support and sometimes a new perspective.

Regular counselling sessions (weekly, every 2 weeks) are important in the beginning and can later o be reduced to one session per month.

Juma is faced with many problems:

1. 'WHERE TO GO'

He does not know if he should go back to Zaire or stay in Tanzania. During follow-up sessions he tells you that his elder brother died last year of AIDS and he is now the eldest son at home, everyone is looking at him. When his elder brother died his father only blamed the mother for this death, saying she did not take care of his children. So Juma is afraid to have the same story 'happening again for his mother'. Here in Tanzania he does not know where to live (everyone rejects him) and how to make a living.

So Juma needs some help to make a decision, you just support and let him find his own answer.

2. JUMA IS AFRAID OF DYING.

For a while Juma is only thinking about death and cannot sleep anymore, does not have appet gets depressed. So you spend a whole session finding out what death means for Juma and try to him back to life' again, repeating again that he is still healthy and that he should think more abc and what to do in life than only thinking of death.

A spiritual person might be helpful for Juma and if he wishes you might arrange a visit for him

3. JUMA GETS SICK.

Juma is coughing and starts panicking. He read everything about HIV and AIDS and knows that people develop TB and now he is afraid that he has TB and will develop AIDS soon and die.

If you are not a medical personnel refer Juma as soon as possible to find out his problem and to treatment as fast as possible. But reassure Juma that even TB can be treated and cured and there need to think that he is going to die now.

4. JUMA MEETS HIS OLD GIRL FRIEND AGAIN.

Juma who did not want any sexual partner in the first time after the shock, now comes back to 'l and part of life is that someone has a partner.

When he meets his former girl friend, they talk a lot but not about AIDS. She seems to be interested having a close relationship with him again and Juma starts panicking. So you can help Juma to fin way how to express his emotions and at the same time to protect the girl and also himself. You a discuss with him if she should know about his infection.

The list can go on and on, there are always different problems at different stages of the infection. Y assist the client to COPE with all the different stages, but not to SOLVE all the problems.

Case No. 3 Back to MAMA ROSE again (see page No. 29).

Mama Rose is one of your regular patients coming every week while she is in Dar es Salaam and sl is looking forward to seeing you although she is very weak.

During the long term support Mama Rose faces plenty of problems and is always relieved to hav someone to talk to.

1. ROSE GETS MORE SICK.

Rose's health is not getting better. From her symptoms she looks as if she had AIDS and after discussing with Mama Rose a repeated test is taken which turns out to be positive, hence Rose is very sick. Mama Rose is very much shocked about he news and needs a lot of emotional support. Slowly she 'takes' it and tries to save Rose's life. You contact her with a neurologist, who confirms that Rose's problem to walk properly could be the effect of HIV on her brain.

2. 'WHAT ABOUT MY FAMILY'.

Mama Rose is very worried about her other 4 children. What will happen to them when I die? She tells you that she only has one brother who is 'a hopeless guy' and whom she cannot count on. There is also her own mother who is old and weak and needs help herself. All her in laws have 'run away' after her husband died, being afraid of the responsibilities of perhaps of AIDS.

When Mama Rose considers that there is no one who could care, especially for the twins she gets very sad. You bring her into contact with a support group, where she can meet people in similar situations and where she can get advice.

YOU CANNOT SOLVE HER PROBLEM BUT YOU CAN REDUCE THE BURDEN.

3. MAMA ROSE GOES TO A TRADITIONAL HEALER.

Through the support group Mama Rose learns about some traditional medicine which seems to be very promising and not so expensive like others. She comes to get your advice and you encourage her to do whatever she feels is good for her, but telling her not to mix up traditional and modern treatment. always doing one thing at a time.

4. MAMA ROSE IS ANGRY.

Mama Rose is fighting 'with God and the world'. Again she thinks 'why me', 'why did my husban die', 'why does my child have AIDS', 'what did I do wrong', 'I have been always faithful' and sh comes to see you, being for the first time also aggressive towards you. She tells you that it is very eas for you to talk so nicely, because 'you don't have it!' you get annoyed first, thinking how unthankfi Mama Rose is to you, who has done so much for her but then you remember that it is normal. Yo don't respond to her aggressive behaviour and tell her how much you understand her. Your remai 'the good friend' instead of 'the disappointed helper' Mama Rose cools down again and when sh leaves she is more at ease. As you go on counselling Mama Rose there are many more problen turning up, sometimes problems repeat.

BE FLEXIBLE AND HELP MAMA ROSE CARRY HER BURDEN, THERE IS NO ONE ELSE.

No. 4 Back to MZEE FADHILI again (see page No. 30)

After two weeks you see Mzee Fadhili accompanied by an older woman who is very fat and loo angry and by a little girl who looks very weak and is shy. Mama Mwajuma carries Furaha on her ba and Mama Furaha has to sit down.

You don't know how to start and after greeting them all you decide to talk to Mzee Fadhili first. F the first time he looks worried and tired and talks about the situation at home. He told both wives tl his 'doctor' want to see them both, and Mama Mwajuma especially had lots of questions and did r want to come, while Mama Furaha always agrees to everything. He could not tell them why.

You call in Mama Mwajuma and even without asking any questions she starts talking about how h her husband treated her and how much her children suffer since he brought this women and now h even sick. 'She only brought bad luck into our house' she says and looks really angry. You feel to t about HIV and AIDS will be too much, so you just give Mama Mwajuma a chance to 'let out' feelings but tell her that you would like to see her from time to time and she agrees. Before she g off you tell her how much you appreciate her co-operation and also her concern for the children ; for the first time you see Mama Mwajuma smiling.

When Mama Furaha comes in, Mama Mwajuma waits outside with the baby while Mzee Fadhi inside your office. Mama Furaha looks young and is very weak. You enquire about her health and

hardly dare talk, so Mzee Fadhili answers all her questions. When you look at Mam her name is just the opposite of what she looks like and introducing AIDS now cc rest'.

So, you tell her that her husband was sick and that also she is sick and this might l problems. You reassure her that you are going to refer her to a doctor who will do all t and start treatment as soon as possible but that also you like to see her from time agrees. You also connect Furaha with a doctor who can do a check-up and treat her.

The sessions with Mzee Fadhili and his family go on for years and you are dealing with situation.

It is not only a man who has TB and HIV infection, no it is complex family situatic misunderstanding which are all brought to you and the HIV infection of the bread-winr only increases the tension at home. Besides medical problems and family problems, lot about economic problems, because besides Mzee Fadhili's 2 wives there are 12 cared for:

Finally the two wives of Mzee Fadhili are tested and also Furaha. Mama Mwajuma t negative, while Mama Furaha and Furaha are both positive.

After Mama Mwajuma has 'cooled down' and is less angry, you can win her confidence talking over the care taker-role of the whole family. Furaha dies after two months only ar Mama Furaha is also dead, Mzee Fadhili is still 'around' but weak and is more and mor his spiritual well being. 'It is God's will', he always repeats and it gives him a lot of coura for his life. And besides, feeling often 'down' yourself when you hear all these sad 'stor that you have learned a lot.

Point to note:

Finally we would like to make the suggestion for any counsellor:

Monitor systematically all patients in order to write down all relevant data about tl the counselling services provided, the progress and problems.

A simple questionnaire could be helpful (see Appendix)

8. COUNSELLING SPECIAL GROUPS.

This book aims at teaching counsellors to know about general counselling skills, with speci sis on the STD/HIV/AIDS counselling. The counselling skill a counsellor applies are always ones: It is just that a good counsellor has to get more in depth knowledge about each new di about the psychosocial dynamics of each group.

SPECIAL GROUPS NEED SPECIAL ATTENTION!

Before counselling a new group a counsellor has to study the social, psychological and dynamics of this new setting.

To talk to teenagers and young people is definitely different from talking to old church leade

A counsellor needs to have good knowledge about each group in order to do a satisfying job. I a nurse who has worked for many years on a maternity ward and is later transferred to a psy

ward. Besides the different technical/ clinical/ administrative knowledge she also needs to know about the psychological/ emotional dynamics of these patients and the new working set-up.

8.1 FAMILY COUNSELLING.

A family in Tanzania is not necessarily a mother, father and children, it can be an extended family with children from different related families who live together and who feel like a family. It also can be a single mother, living with all her children and some of her relatives. A counsellor has to be open for different compositions of families.

The family is usually the main source of care and support and the care which a client/patient requires depends on the stage of his/her infection. In case the person gets more sick, the demand on the family also becomes bigger. The time and energy required for the family to take care of an AIDS patient and also the emotionally involvement usually draws the family away from all other activities and can sometimes fully occupy them. It also can be a financial burden.

The family at the same time is emotionally involved, they might have the same psychological reactions to the news of someone in the family being infected (shock, denial, anger, bargaining, depression and acceptance). They also might be afraid of stigma and rejection.
Counselling of families becomes very important. It includes:

- Giving accurate information.

- Helping the client and the family to communicate and to cope.

- Assisting the whole family to find solutions for daily life problems.

- Talking to a family system requires the same counselling skills like talking to an individual, with the big difference that the counsellor is facedwith many different personalities at the same time. This can be confusing and challenging in the beginning.

The counsellor should not forget about confidentiality while addressing a family. Counselling of a family is only possible if the client has fully agreed to share his confidences with the entire family or part of it. If the client only wants one or two people informed (significant others), the counsellor should strictly adhere to these people only. Otherwise it will break the counselling relationship between counselling and client, which is based on trust. Even when a client has accepted to share his confidence with his family, during the counselling sessions, the client always remains the "star" for counsellor, meaning the most important person.

8.2. COUPLE COUNSELLING.

A couple can be a married couple or two people just living together; they might be traditionally married, religiously married or married in the government. They also might be living together without any official recognition, but with a good social recognition of their families, friends and neighbours. A couple is usually a man and a woman, but sometimes it also might be people of the same sex who share their lives. Although this is not very common in Tanzania and usually not accepted, a good counsellor should be open for any composition he/she meets; which means putting your own values away!.

In case of HIV infection there is no law on partner notification in Tanzania, but the guidelines on counselling say, that a counsellor should advise his/her client to inform the partner. Experience in Tanzania shows that this is very difficult, especially for women, because of dependency and fear of being rejected. Men have less problems to inform their partners about their HIV infection.

Although a counsellor advises his/her client to inform the partner, the decision is totally up to the client, and if a client does not want to inform his/her partner, for whatever reason, the counsellor has to accept this, otherwise the counsellor breaks confidentiality. Against the counselling techniques

used with couples are the same ones, it is only that the dynamics might be very different. As a rule try not to get involved or sympathise with one side of the couple. A counsellor is mainly a tool for the couple to facilitate communication.

8.3 COUNSELLING CHILDREN

To counsel children means to know how to communicate with children, to understand their inner world, their way of expressing their emotions and their way of communicating.

Communication with children so far has not been addressed much. In Tanzania traditionally children were always told what to do and had to obey. Misbehaviour was usually punished without asking for reasons. This has changed nowadays although communication is still unknown to many people. A counsellor might have to counsel a child who has lost one or two parent (s) of AIDS or who is infected him/herself.

It is a very difficult and emotionally challenging work for a counsellor.
Adults often do not know how to start talking to a child about a sensitive topic, they are more used to teach or preach instead of communicating.

Again all the counselling techniques are the same, with the difference that a counsellor has to find a way how to establish a relationship with a child, which might be very different from entering a relationship with an adult. There are different possibilities of entering the world of a child, depending on the age; like playing or talking about something very different, or drawing etc. As a rule a counsellor always should "follow" the questions of a child and try to answer them according to the age. A counsellor should always avoid lies, but answer questions in a way and in a language which a child can understand.

A counsellor has to be a "friend" for the child, especially when it comes to emotional/ psychological reactions. Counselling a child can be very demanding for a counsellor, and the counsellor has to be very careful not to get emotionally much involved otherwise has he/she has to seek supervision.

8.4 COUNSELLING YOUTH.

According to the Tanzania Government adolescents are children between 13 and 18 years and youth between 15 to 24 years. The special psychological dynamics of this age group is that they are not really children anymore, but also not adults yet. They are in a transition period which can be very difficult. Lots of physiological, psychological and emotional changes are taking place.
Communication with youth is often different, they usually have their own language and a special code of behaviour, which the counsellor has to study. More techniques on how to reach young people have to be developed. Many approaches are possible (drama, peer group, involving famous people etc.). Also when a counsellor counsels a young person individually, he/she has to find a way how to enter into the world of this person. It is also important to understand the traditional obstacles in communication with young people, e.g. traditionally young people would not openly express their views in front of elder people.

Once the trust is gained, it is important to talk clearly and openly about all topics concerned. Young people usually do not have formal sex education, where all these questions are answered, but they have lots of informal education, which contains lots of false beliefs or concepts. (E.g. "If a young girl has sex for the first time, she cannot become pregnant"). For preventive reasons it is therefore very important to state facts clearly, in a language which is understood by the specific age group and which is adequate.

A good counsellor can help young people to make a decision, the decision also could be to say a genuine "NO".

8.5. COUNSELLING PREGNANT WOMEN

A pregnant woman might be referred for counselling because of her symptoms which suggest HIV infection. The counsellor here has to face many dynamics at the same time: The woman herself might be infected, if so her unborn baby has a good chance to be infected, and her partner also might be infected. If she is HIV infected she also risks getting weaker through pregnancy and delivery. She also might be emotionally more unstable because of being pregnant. As a good counsellor you find out the network, relationship and support system of this woman in order to have a back-up. Again the same counselling techniques are applied but a counsellor has to be much more alert and sensitive to all the different problems and only go ahead with referring for testing when the woman fully agrees and has a good support system. Otherwise supportive counselling might be practised until the client is ready.

8.6. COUNSELLING BLOOD DONORS

A client who wants to donate blood, usually for a relative or a friend who is very sick, has a good intention. If this good intention is combined with HIV testing it might become very difficult. Most people do not want to be tested for HIV but are willing to donate blood.

Again a counsellor uses the same counselling techniques, which also might be practised in a group. The counsellor gives lots of technical information and the client should have a choice to decide if he/ she wants to get the test result or not. If a client want to have his/her results, post-test counselling should be arranged within the hospital context.

8.7 COUNSELLING PEOPLE WITH STDs.

People who have sexually transmitted diseases (STDs) are at a higher risk also of contracting HIV and therefore have to be counselled. A client with an STD has to cope with the physiological problem and the medical treatment, which might be very disturbing and painful and also with psychological impact of the disease which is shame and withdrawal from others.

Accurate and simple information on the disease and on the long term management might reduce the anxiety of a patient and also might prevent further infection. Talking about change of behaviour becomes very important during the counselling session.

8.8 COUNSELLING OTHERS.

There are many other special groups who need special attention from the counsellor and again the counsellor first has to get in-depth knowledge on each group and be familiar with the counselling techniques and skills.

Some of other special groups:

Prisoners
Commercial sex workers
Refugees
Truck drives
Drug addicts
People living with HIV
Young women
Terminally ill patients
People in emergencies.

9.0 COUNSELLING IN DIFFERENT SET-UP.

9.1. Hospital -Based Counselling

Hospital-Based Counselling is an important element in the struggle to prevent HIV/AIDS, and ir helping those who are already infected and affected by the AIDS virus to cope better with their situation.

Hospital-Based STD/HIV/AIDS counselling takes place in a hospital set-up and is systematic, that is, it is done before the blood is drawn for HIV antibody testing, after the results of the test are given, and after the client (patient) is discharged from the hospital to ensure that the person is coping with the situation at home. Counselling in a hospital set-up is mostly combined with testing and if the client/ patient is handled by more than one person a system for maintaining confidentiality has to be established.

The hospital-based counsellor has to be well selected, well trained and has to accept the professional ethics of a counsellor.

9.2 Counselling in Home-Based Care

Counselling in home-based care is the next step after a client/patient is discharged from the hospital and is therefore part of the networking and referral system of a counsellor. A client might go up and down between these two systems many times. In the hospital-based care the counsellor relies on the system "hospital". The home-based care counselling helps those who are affected even more and it is an important element in prevention. In order for counselling in a home-based care set-up to be successful the community has to be studied and involved in the caring process.

10. REFERRAL SYSTEMS AND NETWORKING.

The term "referral" comes from the verb "refer", that is, re-direct or send a person to another person for help. The person at the receiving end is normally an expert in issues related to the need(s) of the person sent to him/her.

Referral Services in Counselling mean the processes counsellors do in referring clients to other helpers for more effective help or counselling.
Important issues to the foregoing,

1. Counsellors never pose as "know – alls". They have limitations/gaps in their expertise. These gaps have to be filled by other professional or professional helpers/counsellors available.

2. Counsellors must make sure they have an inventory of all referral resources in their communities and other easily accessible places.

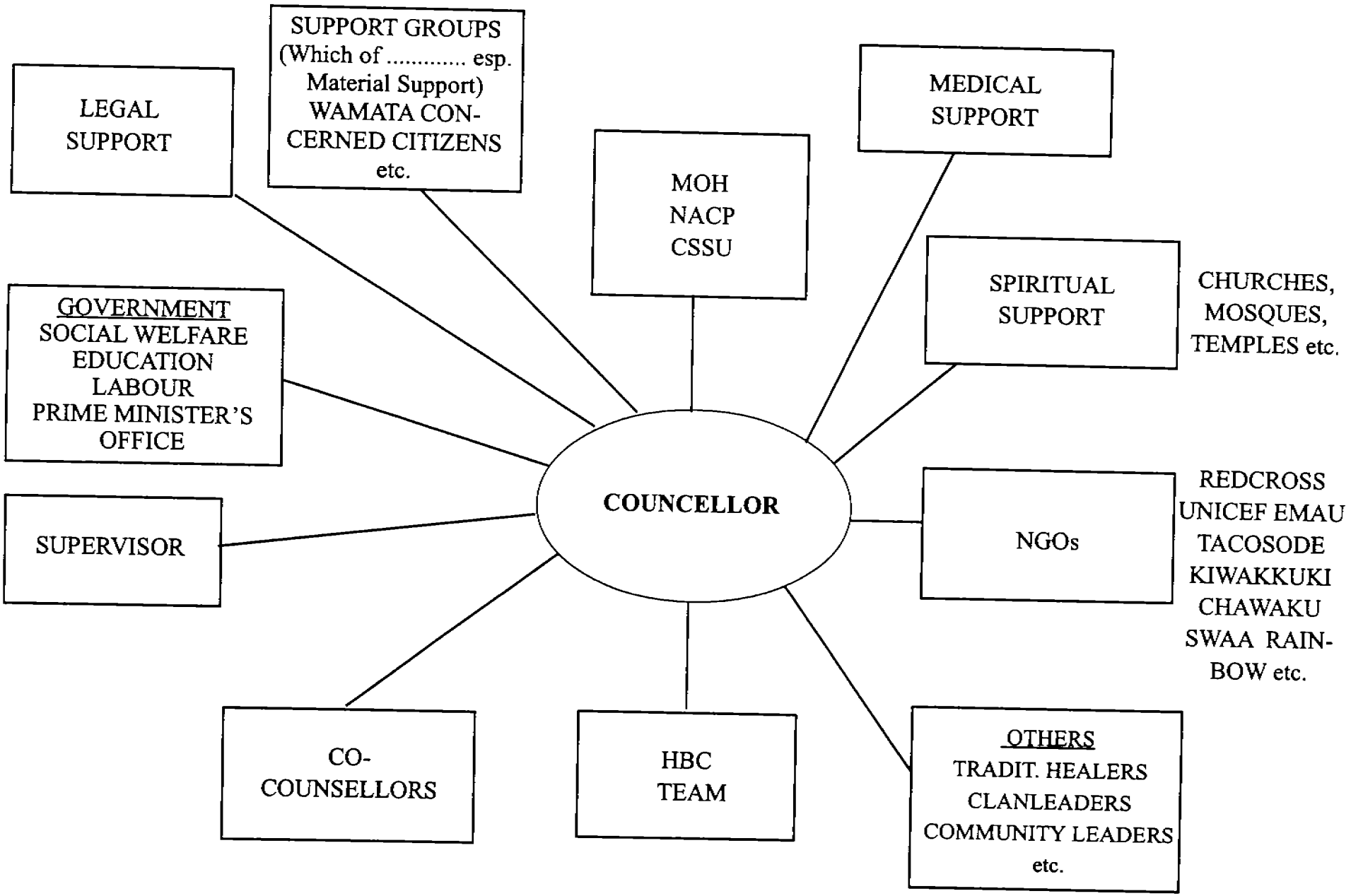
3. Counsellors must establish a clear and cost effective means of contacting and enlisting the identified referral resources for establishing a counselling referral system/network.

4. Counsellors must know how to operate within the established networks e.g, by using referral forms, making personal contacts, etc.

5. Counsellors must update their inventories of referral resources periodically.

B. SALIENT POINTS ON REFERRAL SERVICES.

A counsellor cannot deal with all types of problems. In some cases it will be wise to identify clients who need specialised counselling or who, because of either personal or ethical reasons, cannot be counselled by the current counsellor.


LEGAL SUPPORT
SUPPORT GROUPS (Which of ..... esp. Material Support) WAMATA CON-CERNED CITIZENS etc.
MOH NACP CSSU
MEDICAL SUPPORT
GOVERNMENT SOCIAL WELFARE EDUCATION LABOUR PRIME MINISTER'S OFFICE
SPIRITUAL SUPPORT
CHURCHES, MOSQUES, TEMPLES etc.
COUNCELLOR
SUPERVISOR
NGOs
REDCROSS UNICEF EMAU TACOSODE KIWAKKUKI CHAWAKU SWAA RAIN-BOW etc.
CO-COUNSELLORS
HBC TEAM
OTHERS TRADIT. HEALERS CLANLEADERS COMMUNITY LEADERS etc.

The counsellor needs to have enough information of other counsellors and agencies, including thei specialisation's, in his/her community in order to make necessary referrals.

The counsellor needs to know how to make a referral without causing any disturbance to the client. Referrals involve four steps:

1. Identifying the need to refer
2. Evaluation of potential referral resources
3. Preparing the client for the referral
4. Co-ordinating the transfer.

Referral process is the act of transferring an individual to another person or agency for specialised assistance not available from the original source.

Every counsellor needs to establish self-love and self – care by frequently seeking the support, and advice of colleagues with whom it is possible to be open, vulnerable, etc., about the counselling experiences. Below is a diagram of possible support system (network)for the HIV/AIDS counsellor.

11. The socio-cultural impact on counselling.

Cultural and traditional practices can very much influence the counselling session. It is a fact that culture and tradition have an influence on how people interpret, explain and respond to problems. Like the HIV and AIDS infection different people with different cultures and traditions have different interpretations and explanations. Some say it is God's punishment due to man's sins.

Culture, means habits, expectations, behaviour, rituals, values and beliefs that human groups develop over time. It is culture that makes people learn accepted behaviour, what is right and wrong, through interactions with other people with different ideas and from same physical. Traditions, simply means a way of doing this and usually are handed down or passed on from one generation to another particularly at times of transition puberty or marriage (rituals) or stress (illness and death). It is the time when people learn their culture and backgrounds.

Counsellors should examine their own beliefs so that they can listen openly and without judging people from different backgrounds and culture. They should learn about and respect other people's culture and traditions. They should also not that because of culture, attitudes and behaviour vary within countries, religion and even among groups.

Different people have different culture and traditional practices. With the AIDS epidemic there are different accepted cultural sexual practices which contributes to the spread of HIV infection. All these practices are however done with important reasons depending on the culture of people who are doing it.

Professionals on the other hand talk on behaviour change but then convincing and motivating people is the major counselling task. They will change or even consider it only if the counsellor appreciates the cultural importance of the behaviour to be changed.

8.1 TRADITIONAL PRACTICES AND COUNSELLING.

Tanzania has twenty regions with over 130 tribes, each with its own culture and different traditional practices. What Tanzanians share is the culture of economic structure and the same national language (Swahili), although there are several practices which are common and similar among the majority of the tributes. These include:-

(a) Traditional initiations ngomas and practices ('jando and unyago').

This is found among many tribes where the young people are prepared and taught how to behave within the society and how to become responsible parents. There is however a part of this practice on teaching the adolescents on how to practise sex. This can influence their behaviour especially when they are not married after the ngoma. Preventive counselling should be a routine activity to the adolescents.

(b) Polygamy:

This is another tradition which is culturally accepted among the Moslems. A man can have up to four wives depending on his social and economic status. Traditionally, people who used to have many wives were the Chiefs, Moslems and other important people in the society.

There were good reasons to explain that the Chief wanted to have many children who could be prepared to become heirs when the Chief retires or dies. Another important reason to explain polygamy is that it was practised as a form of child spacing. When a wife gives birth, she will not indulge into sex for up to two years so the husband moves to another wife. Other reasons include increase of manpower to work in the Shamba. If sexual activity is not practised outside the family then there is no chance of the disease coming to the family.

But if one goes out and contracts the disease then it is brought into the polygamous family and wives may probably transmit it to their unborn children. Where it is found impossible to stay faithful in the polygamous marriage advise on means of protection such as the use of condom.

(c) The role of the traditional healers:

Many different tribes have different beliefs on the cause of illness and disease. AIDS is one of the diseases that some people still think it has been caused by witchcraft, bad spirit and that something has to be done. Counsellors should take note that a lot of these traditional healers do not know the nature of the disease and how it is transmitted. Where a client wished to go to a traditional healer, the counsellor should see that the treatment is done with safe instruments to prevent further transmission of the diseases.

(d) Inheritance, extramarital practices, widows and sharing wives:

In many tribes there exists the custom of inheriting wives after their brothers are dead, few have cleansing ceremonies where the brother is dead than the wife had to sleep with her brother-in-law. Sharing wives is also common among some tribes. So if the cause of death is AIDS or if one has AIDS the disease will be transmitted to the other(s). The role of the counsellors is to properly counsel the concerned family in case death has taken place due to HIV infection so that inheritance and cleansing of the widow should not be considered.

In cases where culture allows wife-sharing and extramarital sex (extramarital sex is against the values and norms of many tribes though) it is important for the counsellors to mention things which will justify the change of behaviour. For example, you could tell them that if one of them has AIDS in the family (extended) then the chances were that all of them will get it and if the bread winner die who will take care of the family?. Or the whole family will be deprived. Giving birth to infected children should also be mentioned. Facts alone are not enough hence other means of protection should be mentioned such as the use of condom and proper disposal.

(e) Male, female circumcision, tatoos, mutilations etc:

These practices are discouraged among females and done to males only in the hospitals. However some tribes are still practising it. If the same equipment is used for all and never sterilised there is a likelihood of transmitting the virus from one person to another. Counsellors should give advice on sterilisation of equipment before circumcision for boys and discourage it to girls citing on the effect on child bearing and now AIDS.

(f) Talking about sexual matters:

Traditionally it is not allowed among many tribes to discuss issues related to sex openly even between a wife and husband. The wife is not even allowed to refuse having sex with the husband. In most cases sex was considered mainly for having children and not for pleasure. With the AIDS disease people no longer afford not to discuss these issues.

(i) Counsellors should help people understand the importance of discussing sexual matters, they should help explain things which are not clear to patient and families.

(ii) Counsellors themselves, when counselling a client should be able to see if patients are comfortable discussing sexual matters with somebody who is unfamiliar, of the opposite sex and from different background.

(g) The role of the extended family:

(i) Traditionally counselling has been carried out by respected people in the family. Our grandfathers, grandmothers, aunts and uncles have been offering some counselling. These people need to be exposed to the facts about AIDS so that they can be important people to counsel families.

(ii) Many tribes have rites that the terminally ill patients should be cared and left to die at home. So the counsellor's role is to see and get in touch with all those who perform customary rites like religious leaders, parents, and traditional healers etc. counsellors should observe these rituals that they are properly done in the way the client would want them to be, spiritually and for comfort and protection.

(h) Social mobility affects our culture:

With the rise of industrialisation and urbanisation the kinship ties are somehow weakened. People have to move from their own home areas to work in cities and big towns where there are different cultures and sub-cultures. People are alien to each other. What you find good is not good for others and perhaps more different with another group of people. So counsellors need to consider several factors because they will counsel different people, with different cultures and different backgrounds.

(i) Counsellors need to understand that counselling is not easy. Even experienced counsellors sometimes find it difficult. They can feel shocked and offended.

(ii) In this case counsellors should acknowledge differences which can interfere with the counselling relationship. Admit unfamiliarity with patients culture and know how to question him or her in order to conform to the patient's cultural norms and values.

(iii) Self discipline as well as self-knowledge familiarising yourself with various different cultures and beliefs is required.

(iv) Counselling in this case also requires openness to different ideas and interpretations.

12. Problems faced by Counsellors.

Without facing problems you will not learn more about counselling. So problems are part of the learning process:

(a) You might get a client who has been tested without being informed and now you are called to inform the patient. This situation might happen quite often and puts you in a difficult position.

On one side you feel 'it is impossible' or 'where do I start?'. On the other hand you know that if you don't talk to the client nobody will do it and your responsibility for the patient and the community makes you feel very guilty.

What to do?

Wherever you work you have to develop guidelines for counselling which have to be KNOWN and ACCEPTED by all workers in your Institution. There are guidelines from the Ministry of Health (see Appendix 1) which can be helpful. But to work on guidelines or new policies can take very long.
What to do in the meantime? For example you are working in a hospital and a healthy looking patient is referred to you from surgery who is booked for an operation in the coming week. He has been tested for HIV without his knowledge.

Today the HIV results come out positive and the surgeon has cancelled the patient from the operation list, sending him to you to be 'counselled' before being discharged. What to do?.

You are getting the difficult task to inform the patient that he has HIV infection and therefore cannot be operated anymore. If you refuse to inform the patient because of your own 'policies' (no testing without prior counselling) the patient will be discharged being extremely confused not knowing why he is being discharged without any treatment. It also might create a lot of anxiety in the patient, he might feel that his disease is so serious, that even an operation won't help him. He will go home and might infect his partner or others. He is left all alone.

What other difficulties do you face as a counsellor?

BUT AS A GOOD COUNSELLOR YOU HAVE TO BE FLEXIBLE AND ALSO BE ABLE TO DEAL WITH DIFFICULT SITUATIONS.

(b) Counsellors are often faced with the problem of how to inform the client's partner.

Don't forget that however positive you present it. It always remains a negative and shocking news!

Since there is no law on partner notification in Tanzania it becomes more difficult. In cases of women they often fear that they might be rejected by their partners and experience shows that it is quite common. Again we are in the dilemma of being at the service of the client and also wanting to protect the community.

What to do?

You always explain to your client how important it is to inform the partner, but never inform any partner without the client's consent otherwise you destroy the positive relation ship.

(c) Counsellors always find it difficult to deal with the behaviour of their clients. You know that someone is infected and you talk about behaviour change, knowing very often that clients don't easily change their behaviour.

Think about your own behaviour, like drinking, smocking, eating, things you love to do and how difficult it is to change it. And never expect more from your clients than from yourself. In order to change behaviour you need two things.

(1) You must understand and see the need for changing it **YOURSELF.**
(2) You must have an **ALTERNATIVE** since sexuality is part of our life, we cannot just say 'stop doing it!'

Our diet is also part of life and we cannot just say 'stop eating' we have to be able to give understandable reasons and if possible alternatives.

A woman who increases her income by having boy friends here and there, cannot just stop doing it without having another source of income and we have to discuss with the client what else could be done and why it is important to change behaviour. Although you have your own values and your own life styles be careful not to expect that the client follows your won ideas. Give all the necessary information and then let the client decide on his or her own way.

HELP TO MAKE DECISIONS, DON'T EXPECT EVERYONE TO FOLLOW YOUR WAY.

(d) Counsellors find it difficult to inform the clients about the HIV status, especially the first few clients and very often you will be astonished how well your client "takes it!' Remember most of the clients who have symptoms expect to be HIV infected.

Even if you are scared to break the news don't hide it for too long because the clients is very anxious. If the client comes to collect his or her result don't spend 30 minutes talking about AIDS again, give the news! Say it short and simple and always make sure that you tell the patient her or she has HIV infection if it is not AIDS. Don't give false hope like:

> **'Don't worry'**
> **'You will not die'**
> **'There is medicine'**

If someone tells you that you are HIV infected would you not be worried. Don't give too many advises like,

> **'Take it easy'**
> **'Life goes on'**
> **'Be happy'**

Through experience you will feel more and more comfortable to break the news and also

your client will feel more at ease with an experienced counsellor.

(e) Counsellors often feel it difficult to find a way between encouraging the client and not giving false hope.

NEVER GIVE ANY FALSE HOPE BUT NEVER TAKE AWAY ANY EARTHLY HOPE.

If a client tells you that he or she is taking traditional medicine and feels much better don't discourage your client. If a client feels he can get cured by praying, let him or her go on that is wonderful.

As a counsellor you have to find your way on how to encourage a client without giving wrong information. Time will teach you.

(f) Counsellors may sometimes not have enough knowledge. You might be counselling some one who knows a lot about AIDS and asks you very difficult, technical questions which you might not be able to answer.

Don't be afraid to admit that you don't know certain answers. It is better than pretending to know and giving incomplete or wrong answers. You might be caught with more difficult questions.

BUT YOU HAVE TO IMPROVE YOUR KNOWLEDGE CONSTANTLY, ALWAYS GET THE LATEST INFORMATION AND ALWAYS ASK FOR EXPERT ADVICE.

You are not expected to be an expert when you start!

(g) How to deal with your own emotions.

Especially in the beginning you will be emotionally very touched by your clients and sometimes you might be overwhelmed by your own emotions which can be:

Anxiety You might feel very anxious about how to inform the patient or you even might be anxiously waiting for the patient's result.

Don't forget to establish a positive relationship with your client, who might become like a friend.

Depression At some stage you might get depressed yourself seeing your patients dying, seeing small children suffering, men and women fighting with death.

Always look for other counsellors to exchange experiences with and look for some supervision in order to cope with your own emotions. They are very normal and actually are important for a good counsellor.

Burn-out You might feel 'that's enough' or 'I can't take anymore' you might be physically or emotionally exhausted. Often it happens that when you are burnt-out don't care anymore for your clients.

DON'T FORGET TO TAKE CARE OF YOURSELF

A burnt-out counsellor is not being of any good. So get a rest from time to time and when you have got your strength again continue slowly.

Being aware of your own emotions is as important as being aware of your client's emotion. If you are not aware of yourself your might mix up your emotions with the emotions of the client. Your might feel very depressed and think that your patient is depressed.

Regular contacts with other counsellors and some supervision from time to time will be helpful.

13. SUPPORT FOR THE COUNSELLOR.

Counselling in HIV infection and disease is a stressful. Each day the counsellor meets people in very difficult situations. Each day the counsellor is confronted with the reality of HIV, illness, death and grief and loss.

What can you do to look after yourself?

Who can you talk about your work?

When we discussed helping people who are experiencing stress we talked of the importance of talking about your feelings. This can relief stress. Sometimes if you have had a particular difficult day or a very stressful interview you feel that you must share this with someone. You wonder if you used the right approach to try to help the person. Your feel that there is no little you can really do to help the person change the situation. However as a counsellor you are aware that maintaining confidentiality is essential.

The counsellor's supervisor is perhaps the first person to talk to. She is well aware of the nature of the work you are encountering and should be able to offer you support.

Sharing with other counsellors is also helpful.

A COUNSELLOR FOR A COUNSELLOR

Counselling is a helping process that helps a person with problems to which an easy solution cannot be found to cope.

We all face problems at one time or another, but our capacities to cope differ. Some people find themselves so mixed up emotionally that it requires another person to help them help themselves cope. The question is that if a counsellor can give such service, does he/she too need a counsellor? The answer is YES. A counsellor can be rewarded with a sense of well-being if he/she can help a person help him/herself find a solution to his/her troubles. However, it can be very distressing if a counsellor finds himself unable to help. In the case of HIV, the situation is more grave because of the nature of the situation they are confronting. In counselling a counsellor can become attached to people and often the magnitude of the problems they are facing can leave one with a void feeling of being useless and may account for the building up of stress. A great part of counsellors work involves giving of ones self. This therefore demands a lot out of him which should be replaced. The soothing encouraging and understanding shoulder if another counsellor is as welcome as a CALABASH of cool water on a hot day. Just as a car may need fuel or servicing after a long journey so does a counsellor in his/her work.

What other things can you do to take care of yourself?

1. Know what your personal limitations are as a counsellor.

   Limit the number of people you become very attached to. Try not to get over attached to people you are offering help to.

2. Know how to reach out for help. We know, as counsellors that it is often difficult to ask for help. We all need help from time to time, however. It is much better to ask for help, and share problems with work as soon as you are experiencing them, that to let things build up.
3. Practise active grieving for people who your are working with who die. Attend the death rituals. Involve yourself in NGOs activities such as Quilt making and Candlelight Memorials.
4. Manage your work effectively. Arriving at the right time in the morning start the day off well. Your will not feel so rushed and under pressure if you on time, and you will have time to greet other people at work properly and liase about any issues that need to be attended to during the day.

   Do not plan to do too much on one day. Over committing yourself causes stress, lets down the people you are offering help to and makes you ineffective. For example it is not realistic to promise to visit several people at their homes in one morning if these people live a wide distance apart. Remember counselling takes time.

   Keeping records and reports up to date daily is a good idea. Plan some time each day to do this. If you let written work build up it will become impossible to do.

   Keep busy while at work. Not doing enough can be as stressful as doing too much. These is always something to do, sometimes to read that will help you in your work. If you are not busy, offer to help another member of staff.

   Try to finish your work on time. It is not a good idea to extend your working day. You need time for yourself as well! It is a good idea to try to "switch off" when you leave work. Sometimes this can be very difficult. Doing something completely different after work is often a good idea. May people find playing some sport can be helpful. You could also practice relaxation exercises!!.

   Caring for yourself is as important as caring of other people.

   !! **GOOD LUCK** !!

APPENDIX 1

GUIDELINES ON TESTING, CONTROL AND MANAGEMENT OF HIV AND AIDS.

I. HIV TESTING.

1. HIV Testing of health individuals will either be unlinked or voluntary. For blood transfusion set ups, all endeavours should be made to provide for unlinked testing.

   Unlinked (or blinded) testing is where all names and identifiers are removed from the blood specimen. It is the optional way of testing for surveillance purpose. There is no possibility of identification of individuals and therefore no possibility of a negative effect on the programme if done properly.

   For all other indications for testing where unlinked testing cannot be applied anonymous (e.g. coding) is advised.

In planning anonymous but linked testing such as in cohort studies, it is essential that:

(a) The test subjects have a choice of being told the results or not.
(b) The test subjects know in advance that they will be tested.
(c) Names and other identifiers are kept by only one person with full confidentiality ensured.

2. All testing will be confidential. Breaches of confidentiality destroy the trust that is essential between the testing programme staff and individuals and groups involved and may have a serious, and sometimes irreversible effect on the programme.

3. No person will be notified of a test result who did not know his blood was tested or who says he did not want to know.

4. For suspected patients, testing for HIV diagnosis can be done without prior consent in cases where they may not be in a position to give such consent. Counselling will be made available for patients and, if desired by patient, for the family.

5. Pre and post test counselling services should be made available to all places where individuals are to be notified of test results. Counselling should be confidential.

6. For surveillance purposes, one test system is sufficient although confirmation may be applied according to research and other needs.

7. For the purpose of screening blood donations to ensure a safe blood supply, identification and notification of results are unnecessary. For donors who want to know results, alternative voluntary linked but anonymous testing will be made available.

8. All research protocols, proposals involving testing of subjects or patients must conform with these guidelines and be approved by MOH or the responsible authorities at the site involved on advice of the research sub-committee of the Technical Advisory Committee (TAC). The results of the research must be shared with all the people involved and clearance must be given by MOH before the paper is presented or published.

9. HIV testing should not be mandatory for any marriage. Individuals are free to choose toknow their own HIV status and if they want to notify their partner, spouse, or future spouse.

10. Neither physicians nor anybody else is free to notify any other person other than the person tested of the antibody status of unless on the request of the tested person. Physicians can encourage seropositive persons to notify sexual partners on the context of adequate counselling for both persons, only after the free choice of both persons.

11. Screening of HIV infection will be mandatory for travellers or migrants into or out of the country. As HIV infection does not necessarily affect the state of health or performance of an individual, it is not by itself grounds for the refusal of employment and will not be mandatory for those seeking employment in any public or private organisation or enterprise.

II. MANAGEMENT OF AIDS AND HIV INFECTION.

Rationale:

AIDS is a uniformly fatal syndrome of opportunistic diseases resulting from immunodeficiency. Currently, there are effective therapies for several of those opportunistic diseases, but there is no effective therapy for the underlying immunodeficiency. The goal of management of AIDS and HIV infections to provide optimally humane and supportive care for the patient and his relatives. This care must preserve confidentiality to avoid discrimination, and allow patients, as much as possible, to live normal productive lives.

A. AIDS Clinical Management

1. Health-care worker training and protection:
All health-care workers will receive on-going training in the epidemiology and management of AIDS and HIV infection. The goals of this training will be to eliminate unreasonable fear among health-care workers and establish them as effective counsellors and sources of accurate information about AIDS, to optimize diagnosis and patient management, to ensure confidentiality, and to protect health-care workers from transmission. In particular, health-care workers will be taught to handle all blood and secretions as if these were HIV infected rather than to try to determine which patients are HIV-infected.

2. Treatment facilities:

Attempts will be made to treat AIDS patients within the existing health care system while working on development of domiciliary health care services. No health care institution will have the right to refuse to provide treatment to AIDS patients or those with HIV infection. Isolation of AIDS patients is not necessary except when they present with usual indications for isolation.

3. Community-based supportive services:

NACP will encourage the development of community-based supportive services for AIDS patients. These services will be co-ordinated with the patient's health-care providers and make effective use of resources such as the patient's family, community leaders/members, the clergy, teachers, social workers, and humanitarian organisations.

4. **A. Counselling:**

Patients with AIDS will have access to trained counsellors who can give them accurate information about the implications of a diagnosis of AIDS, the epidemiology of HIV, and ways in which they can protect their families and casual contacts from HIV transmission.

B. Right of persons with HIV infection and AIDS:

Persons with HIV infection with or without AIDS shall be guaranteed basic rights, such as the right to protection of privacy, to employment, to education in schools, to use of public transport and housing. Reasons receiving advise, counselling and treatment for AIDS will be assured of the same rights to privacy and confidentiality as persons receiving treatment for any other disease.

III. PREVENTION OF SEXUAL TRANSMISSION

Rationale:

The transmission of AIDS is known to be associated with certain patterns of sexual behaviour. In particular, an individual's risk or infection increases with the number of sexual partners with whom he or she engages in unprotected sexual intercourse. Prevention, therefore, depends on action aimed at changing the behaviour of those at risk and of preventing the adoption of such behaviour in others. Evidence from other African countries shows that the most effective strategies aim at increasing both public awareness and to provide specific education and advice to risk groups.

A. Information and Education.

1. **General**
   All persons have the right to information, education and counselling on matters relating to AIDS.

2. **Schools and Training Institutions**
   Education on matters relating to AIDS will be integrated into schools and training institutions curricula.

3. **Media Institutions**
   All Media institutions will be encouraged to take an active and responsible part in their dissemi nation of information and education on AIDS and AIDS related topics.

4. **Community Involvement**
   All government and non-government sectors and institutions in our society have a duty to participate in AIDS control activities.

B. Education and Counselling of groups involved in high risk behaviour.

1. **Persons involved in high risk behaviour**
   Special education and counselling, including occupational and social rehabilitation, will be targeted to these groups involved in high risk behaviour.

2. **Person with AIDS and HIV infection**
   Counselling of persons with AIDS and HIV infection will become a part of training of all workers involved in the areas of health, education and social welfare, and any other occupations concerned with the life of the community.

C. Condoms

Condoms, when properly used, have been found to decrease the risk of sexual transmission. Since we know that it will take time for people to change their predisposing behaviour patterns, condoms of high quality will be made widely available. As much as possible, counselling and instructions on correct condom use will be made a pre-requisite to condom issuing.

D. Prevention and treatment of sexually transmitted disease

Because of their proven role in facilitating HIV transmission, sexually transmitted disease will be targeted for improved prevention and treatment efforts, including increased health education, counselling of patients as well as upgraded training of health-care workers.

IV. PREVENTION OF TRANSMISSION THROUGH BLOOD TRANSFUSSION

Mandatory screening will be introduced in all Health Institutions, public and private to ensure blood transfusion.

2. Promotion of blood donation.

To enable an effective programme of blood screening while ensuring the supply of blood, public education will be used to increase the pool of potential donors and to assure them that blood donation is not risk factor for HIV infection.

V. PREVENTION OF TRANSMISSION THROUGH SKIN PIERCING INSTRUMENTS.

Rationale.

The risk of HIV transmission through routine use of skin-piercing instruments is small, but concern about this risk poses a threat to immunisation and other health care programmes. The risk can be eliminated by implementation of procedures to ensure use of sterile instruments.

A. Use of sterile re-usable equipment:

Because of the risk that disposable equipment will not be disposed of and will be re-used with out sterilization, re-usable skin-piercing equipment, including needles and syringes, will be supplied to the small health facilities whereas the disposable needles and syringes when available will be supplied to the consultant and regional hospital.

Care will be taken to ensure that health-care workers have adequate training concerning the need and procedures for sterilization, have adequate supplies of reusable equipment to allow sterilization, and have adequate sterilization, equipment.

B. Education of Consumers.

Public education will aim at ensuring that consumers of health-care services demand sterile skin-piercing equipment and avoid practitioners likely to use unsterilezed equipment.

VI. PREVENTION OF PRENATAL TRANSMISSION.

Rationale

The prognosis for a child born to an HIV-infected mother is poor.
Approximately, half of HIV infected pregnant women transmit infection to their new-borns, and approximately half of HIV infected new-borns will die in the first year of life. Current data indicate that most prenatal transmission occurs during pregnancy. Routine identification of HIV-infected women through testing is likely to be expensive and difficult.

A. General

Prevention of prenatal transmission will rely principally on prevention of transmission in the community.

B. Specific issues

1. Pregnancy prevention in HIV-infected women

HIV-infected women of child-bearing age and/or their sexual partners will be educated about the risks of prenatal transmission and offered the option of contraception.

2. Breast feeding

Because the risk of HIV transmission through breast feeding is very much lower than the risk of death from diarrhoea and malnutrition for non-breast fed infants, HIV-infected mothers will be encouraged to breast feed if they are physically fit.

APPENDIX 2

PRE-MARITAL AIDS-VIRUS TEST.

1. INTRODUCTION

AIDS is a new disease in the world, having been with us only since 1981. It was in 1983 that simultaneously Dr. Robert Gallo and Dr. Luc Montaionier announced their independent discovery of the causative agent, a virus. The virus believed to be the cause of AIDS belongs to the retrovirus group and is currently called Human Immune Deficiency Virus (HIV). There are two sub-types of this virus: HIV1 which is found in all parts of the world and HIV2 mainly found but not confined to West Africa. The discovery of the AIDS virus opened many doors leading to various advances in the search for knowledge and understanding of the new disease. One such break-through was the development of test for the detection of HIV antibodies and antigen in serum. It became possible to diagnose more reliably an AIDS patient. These tests have had to be refined subsequently and gradually until now we have fairly reliable tests for the detection of HIV antibodies and antigens.

The discovery of HIV tests invariably created a role of HIV testing in the control of HIV infection. It became possible to embark on blood donor screening programmes aimed at ensuring a reduction in the rate of transmission through blood transfusion.

As the public acquire the most basic information about HIV infection and AIDS, the issue of testing all women in child bearing age so as to advice those found to be positive against conceiving, or testing all pregnant mothers and counsel those found to be positive as means of reducing the rate of transmission of the HIV infection from mother to child, are frequently brought up.

It is also frequently suggested that we offer HIV testing to youths before they get married so as to advise discordant couples against marriage.

2. WHY PRE-MARITAL TESTING?

Most of the people in Tanzania would go into marriage with acquiring and raising children as their main objective. This is so basic an objective that most marriages would cease to be if this primary objective was not achieved. Sometimes it is not an issue handled at individual level but rather the family, and society are often involved. Marriage is a public issue and procreation is the main goal. Since there is no private marriage, as the entire society is involved at one stage or another in arranging for it, so will the society be there to evaluate it. Both the subject and the goal of marriage are society issues.

If therefore, it were to be known before hand that the marriage will not raise children especially if it were to be know that the act of getting children will be dangerous to one of the parents to the extent of costing them their lives and that the children so acquired may not survive, this kind of marriage would be judged better not taking place. It would seem, therefore, important to some individuals that the couple be tested and marriage carried out only after both couples have been cleared of having HIV infection.

3. WHEN IT CAN BE DONE

Supposing that this is what society wants and that we had both the resources and capacity to offer a pre-marital HIV test to all those that what to go into marriage. The timing of this test would be important. At want stage of their courtship are the couples advised to come forward for a HIV test? Obviously very early in their relationship. This is the time when their relationship had not yet become public affair. Should the test be positive for one of the couples and a decision made to terminate the relationship both families will not have been involved. If the test is done late, the relationship is public and quite a lot of expenses such as dowry etc. may have already been incurred. A positive test to one of the couples at this stage may have economical and psychological repercussions not only to the individual, but to their families as well.

Another reason why the test should be done very early in the relationship is that, at this stage the couples are not likely to have engaged in sexual intercourse. For it will be futile to terminate a relationship on the basis of a positive HIV test result for couples who have already had a sexual relationship. It is desirable that the couple go to their doctor voluntarily, together and at a very early stage in their courtship for counselling. The regulations are that this service is voluntary and confidential. It must not be forced by parents or religious leaders who, in any case, must not have access to test results except by the consent of the couples.

4. PRE-TESTING COUNSELLING

Now let us examine the technical aspect of HIV testing. Before anybody is tested they must be counselled. During this pre-test counselling the individual is asked about pat and current behaviour or situations that might have pre-disposed them to HIV infection. The meaning of positive and negative test result are explained to the individual. The difference between HIV infection and AIDS are also explained. Furthermore, the implications of being HIV infected in terms of precautions in normal life are explored **BEFORE THE TEST IS CARRIED OUT**.

The patient is the asked if after the pre-test counselling they still think they would like to know the result.

Throughout the pre-test counselling which may take more than one session, the Doctor is quietly assessing his/her client. What is the psychological set up of the client? Is he/she likely to act rationally in case of bad news? This assessment by the doctor continues until the day he releases the result or decides that this client just cannot take the news. For the mot sad event is that of having a client commit suicide on the basis of a positive test result being revealed. It reflects failure in counselling techniques.

Other adverse reaction may include anger in which case the client decides to revenge against society by knowingly engaging in activities likely to spread HIV infection.

As in pre-marital pre-test counselling one is dealing with young individuals in their prime of youth the latter type of adverse reaction to poor counselling will have a telling effect on society as these youths get denied the right of a formal, stable, sexual relationships in marriage.

5. POST-TESTING COUNSELLING

Since a well prepared and taken pre-test counselling session might give a better
prediction of the HIV status of the individual, effort must be made throughout the counselling sessions to prepare him/her to accept the likely results. This is important particularly in pre-marital HIV testing as concealing the results might not be practical since it is needed for a specific course. The nature of the post-test counselling session discussion will usually depend on the messages already gathered and the results in hand. e have to remember though that during this time most clients are over sensitive on any information give, and they need a better relaxation to avoid any uncalled for disaster.

Sometimes the post-test counselling sessions can be arranged - (with the clients consent) to include another person whom the client would like to share the information with. If this is the case, the idea has to be introduced preferably long before the results come out. This is particularly important when results turn out to be positive, and the client desires only a few close family members or friends to have the news first before it goes to any one else. We have to remember that in such a case clients need all available support - psychological, physical etc. to withstand and to get used to the bad news-particularly in this situation whereby the ad needs have to be communicated to a third person any way.

6. RELEASING THE RESULTS

There have been stories of couples getting married after a negative pre-martial HIV test. A few such marriages have resulted into one of the couples developing symptoms and signs of AIDS some months after marriage. The public fail to understand how this can happen. Some suggest that the medical personnel involved may have been influenced to release a false test result. All this may be possible but the fact to remember is that the technology that we are currently applying cannot reliably enable a doctor to state conclusively that the individual does not have the HIV infection.

Some of the negative results could belong to individuals who have the HIV infection in such early stages that the antibodies to the virus have not been produced at sufficient enough quantities to be detected by the test we use.

A very small proportion could be a result of the test limitation bringing up a false negative result, and yet in a small proportion of individuals the HIV infection may be advanced but their body unable to form antibodies at sufficient quantities to be detected by the antibody screening test.

Let us now examine the implications of a positive antibody screening test. In the laboratory, the blood is tested using one of the routine screening tests. The ELISA Organon, Serodia HIV-Chek, Karpas test, Welcosyme are all such tests. Most of these are highly sensitive tests. This means that some for the positive results my not be true positive but rather false positive reaction.

This shortcoming is not a serious setback when using the test for blood donor screening because it only means that approximately 10% of the blood that could have been safely transfused is discarded. This is the loss as a result of a test limitation. If these tests were to be used for pre-martial HIV testing and their results taken as the sole basis for pre-marital counselling, 10% of the young people would be wrongly made to believe they were HIV infected. This could have very serious repercussions in their lives.

Suppose they react with anger and decide to riot sexually. Then we will have them acquiring the HIV infection as a result of their reaction to our wrong information. We will have to take responsibility for this; and what a responsibility! That is why a confirmation test, the Western Blot, has to be performed to all the blood samples positive by the screening test. Serum is positive for HIV antibodies when both the screening and the confirmation test are positive. Only such positive result must be communicated.

In all cases, it takes in the majority of cases up to 12 weeks from the time of infection with HIV to production of sufficient quantities of antibodies as may be detected by an HIV test.

This is the period known as the "window period" during which an antibody detecting test reads negative even when the individual already has HIV and is infectious. Following a negative test results and provided that the individual assumes a risk-free life for three months even a second negative test result almost confirms that the individual is most likely not infected with HIV. It is almost conforms that the individual is most likely not infected with HIV. It is therefore not that easy to proclaim a couple as being negative on the basis of a single negative result.

7. ECONOMIC IMPLICATIONS

As it is now, the price for the screening test are: ELISA Organon USD 1.0 per test, HIV Check (Dupont) USD 3.0 per test, Serodia USD 0.6 per test, while the Western Blot costs USD 20.0 pr test. On this basis the cot for every positive specimen is at least USD 20.0. It has to be noted that the cost of a Confirmatory test (Western Blot) is a limitation. That is why this test is found only at the consultant hospitals and even in those hospitals not in sufficient quantities to support an activity such as pre-martial HIV tasting. Our regulations however, are that a Confirmatory Western Blot test is mandatory if a positive test result is going to be notified to an asymptomatic individual.

It will therefore be seen from the foregoing that the activity of pre-martial testing has a cost to it. The economic implications of ensuring a programme which will respond to the requirements of testing call couples before marriage have to be examined. To be of any Public Health benefit, This programme must cover the majority of couples if not all. Ho many marriages take place in the country? This information plus our knowledge of kits price will roughly give us the idea of the amount of money required for this programme.

8. SOCIAL IMPLICATION

There is also the psychological cost for the young man and woman who will not marry because they have been found to be HIV positive. One advice we give to the general public to avoid AIDS is that they must stick to one faithful sexual partner. To these young couples the message must be that they must use a condom for every sexual intercourse throughout their life.

We advise them that they must inform their sexual partners of their HIV sero status. All these are issues which must be addressed with the knowledge that most these youths are still healthy and have the sexual urge common to all youths of their age.

If these youths are not going to adhere to advice given, there may be less Public Health benefit accruing from this pre-martial testing programme than if they were just allowed to get married and stick to each other. It is easier for a married individual to stick to their partner than a sero-positive youth who is not married to adhere to advice aiming at protecting the public.

We have to imagine a situation whereby the information regarding a couple's HIV status is to be communicated through a third party as well, a religious body, a family or social group for example as is the case in pre-martial testing. This leads to a lot more psycho-social destabilisation among couples, and may eventually lead to even more social unrest if not destruction. Many of the relevant bodies conducting marriage proceedings lack the capacity to contain this situation at the moment and become helpless when the unexpected come true. This is often true when pre-marital testing is done a few weeks or days before marriage takes place.

Appendix 3

MYTH ABOUT AIDS

There are many myths associated with HIV transmission but the truth is: -

YOU CAN'T GET AIDS FROM:

- **Used clothing**
- **Kissing**
- **Hugging**
- **Sitting on toilet seats**
- **Mosquitoes**
- **Bed bugs**
- **Food**
- **Water**
- **Plates**
- **Spoons**
- **Glasses**
- **Social contact**
- **By sneezing**
- **Casual contact**
- **From tears**
- **By donating blood**
- **By dancing**
- **From a bus**
- **From a classroom**
- **By talking**
- **From a crowded room**
- **Eating together**

Appendix 4

FACT SHEET FOR PEOPLE WITH HIV/AIDS

If you have learnt that you have HIV/AIDS then please read this fact sheet carefully.

Don't panic

Having the HIV virus in your body does not mean that you have AIDS. After the virus enters the body of a person, it takes sometime to weaken and damage the body's immune system and cause AIDS. The period between getting the HIV virus and having AIDS varies from person to person from a few months to several years.

Be brave

You will be upset. Feelings such as anger, guilt, fear and sorrow are natural at a time like this. But try to accept your situation and look ahead. Remember, there is a good chance that you have some more years of useful productive life ahead of you.

Don't be mislead by false claims

There is yet no medicine to cure AIDS. Don't waste you time and money searching for a magic cure. You might be disappointed and lose our money.

Whom to tell?

Living alone with the knowledge that you have HIV can be difficult. But before you tell others think very carefully about whom to tell because AIDS is a dangerous disease and many people are scared about it. People may behave in a manner that could hurt you. Share your information with someone you can trust who will support you and help you.

What helpful treatment

There is yet no medicine available to cure AIDS but there are many strong medicine to fight the serious infections. Moreover there are useful medicine to provide relief from troublesome symptoms such as diarrhoea and fever. Therefore attend a clinic or hospital for regular check-up so you can be given effective treatment and correct advice. This sill help you to stay well as long as possible.

How to help yourself

It helps to develop a positive attitude. Stop thinking about dying from AIDS. Instead think about living with HIV.

Try to eat adequate, nutritious food and avoid mental strain.
Keep busy and active. There is no need for you to stop work. try to live as normal a life as you possibly can.

Avoid casual sex. You might get germs that cause other sexually transmitted disease, such as syphilis, gonorrhoea and chancroid. Because the body's defence system is weakened by the HIV virus a dangerous life threatening infection could result.

Don't forget that

The HIV virus is mainly spread by sexual contact with an infected person. Living with, eating with and caring for an infected person is safe. AIDS is an illness not a sin.

Just like other patients, AIDS patients need our compassion , support and understanding.

If you need more information about the HIV virus and AIDS then contact your Regional or District AIDS Coordinator.

Appendix 5

QUESTIONS AND ANSWERS

1. **What is AIDS?**
   Acquired Immune Deficiency Syndrome (AIDS) is a disease in which the body's natural immune system breaks down, leaving it unable to fight off infections. A person with AIDS gets illnesses that are little or no threat to someone with a healthy immune system.

2. **What causes AIDS**
   AIDS is caused by a virus called Human Immuno deficiency Virus (HIV). HIV is sexually transmitted and blood borne virus.

3. **Do all HIV infected people have AIDS**
   No. It can take years for illness to appear. Most people infected with HIV may have initial flu-like symptoms for a few days, and then for years without any symptoms. People may not even know they are infected. Illness may then develop, varying in severity from mild to extremely serious. AIDS is the most severe result of HIV infection,

4. **Is there a cure for AIDS?**
   There is still no cure fro AIDS.

5. **How is HIV transmitted?**
   HIV is not an easily transmissible virus. HIV is spread by direct contact with infected blood, semen, vaginal secretions. The virus can not be transmitted through air, water, food or casual body contact

6. **How infectious is HIV?**
   Unlike most viral infections-colds, flue measles, etc.-HIV is not transmitted through sneezing, coughing, eating or drinking from common utensils or merely being around an infected person. Casual contact with HIV infected people does not place others at risk. No cases have ever been found where HIV has been transmitted through casual (non-sexual) contact with a household member, relative, co-worker for friend.

7. What behaviour increases the risk of HIV infection?
   Behaviours that may put an individual at increased risk for HIV infection include:

- having unprotected sexual intercourse with a person whose past history or current health status is unknown;

- HIV-infected women can also pass the virus to their children during pregnancy.

8. **Who is at risk for AIDS**
   Anyone who engages in high risk behaviours can be come infected with HIV and develop AIDS. Most cases of AIDS are linked with sexual activity.

9. **What is the risk o getting HIV from a blood transfusion**
   The risk of HIV infection and AIDS through a blood transfusion has been significantly reduced through health history screening and blood donation testing.

10. **Why is HIV more easily transmitted from men to women during vaginal intercourse?**
HIV appears to be more highly concentrated in semen than in vaginal secretions. Women are also likely to have longer exposure t the virus because semen is retained in the vagina after intercourse, than from women to men.

11. **Does frequent sexual contact increase the risk of HIV infection?**
Unprotected sexual intercourse with many different partners increases the risk of coming into contact with someone who is infected with HIV, as well as other sexually transmitted disease, including syphilis, gonorrhoea and herpes.

12. **Can other sexually transmissible diseases increase the risk of HIV?**
Any sore caused by herpes gonorrhoea or syphilis could make it easier for HIV to enter the blood stream during sexual contact. Studies show higher rates of HIV infections among men and women who have had syphilis.

13. **Can use of a condom during sex reduce the risk of HIV infection?**
Use of latex condom during sex can reduce the risk of HIV infection since it minimizes direct contact with semen and vaginal secretions, fluids know to carry the virus in infected people. since condoms are not 100% safe, people should not rely on them as their only defence against HIV. It is safest to avoid sexual intercourse unless you know for certain your partner is not infected.

14. **Can a person with no symptoms transmit HIV?**
Yes. Initially, most HIV infected people have no symptoms and are not even aware they are infected. Any infected person may transmit the virus to another person through sexual contact.

15. **How can people reduce their risk of getting HIV through sexual contact?**
All sexually active people should avoid unprotected sexual contact which involves direct ex change of body fluids (semen, vaginal secretions, blood) unless they know for certain the partners is not infected with HIV. Use of a condom during all sexual intercourse, can reduce the risk of direct contact with infected body fluids.

16. **Can you get infected by being in the same house with a person with AIDS?**
Many sties have shown that transmission of HIV through causal contact does not occur, even among family members living in the same house.

17. **Can you get infected by drinking from the same glass or eating from he same dishes as a person with AIDS?**
A decade of experience demonstrates that HIV is not transited in households where people may drink or eat from common dishes or utensils. the virus does not survive well outside of the body and would be killed by normal washing of dishes.

18. **Can you get HIV infection from public toilets, drinking fountains, restaurants, telephones or public transportation?**

19. **Can you get HIV from using someone's razor or toothbrush?**
There is no evidence that HIV is spread through any form of causal contact, including hand shakes, bumping together in crowds, contact sport or even casual kissing.

20. **Can you get HIV from using someone's razor or toothbrush?**
There are so far no cases of HIV infection linked with sharing razors or toothbrushes. Since toothbrushes. Since toothbrushes and razors can cause cuts and scrapes, it would be wise to avoid sharing personal items that may come into contact with the blood of another person.

21. **Can you get HIV from a co-worker?**
No. HIV is not transmitted through casual contact. No cases of AIDS have developed among causal friends or co-workers of HIV infected people. There is no evidence that being around someone with HIV/AIDS, even for n extend period of time, puts you at risk.

22. **What is the risk of living in a neighbourhood that has a hospital or home for people with AIDS?**
None, since HIV is not transmitted through the air or through any kind of casual contact.

23. **Can mosquitoes transmit HIV?**
There is no evidence that mosquitoes or other insects play any role in the transmission of HIV to humans.

24. **Can you get HIV from ear piercing or tattoo needless?**
So far, no AIDS cases have been reported linked with ear piercing or tattooing. To guard against possible infection, all needles o equipment used for these procedures should be sterilised between each use.

AIDS INCIDENCE

25. **Is AIDS occurring only in our country?**
AIDS is a world-wide phenomenon. AIDS has been reported in United States, Canada, most Europe countries, African countries, the Caribbean, south America, Australia and several other places including the Middle East and Asia.

DIAGNOSIS AND TREATMENT

26. **Is there a test for AIDS?**
A blood test can detect antibodies (substance produced in the blood to fight disease organisms) to HIV, the virus that causes AIDS. Presence of these antibodies in the bloodstream means that a person has been infected with the virus. A positive test does not mean a person has AIDS or will develop AIDS. There are other laboratory tests that can detect immune system damage associated with HIV infection and AIDS.

27. **How soon after becoming infected with HIV do antibodies develop?**
Most people infected with HIV develop antiboides to the virus within a few weeks, but it can also take seeral months. All infected people whether or not they have developed antiboides that show up on a test, can transmit the virus to others thorugh sexual contact.

28. **What are the early symptoms of HIV infection?**
Many people infected with HIV have no symtoms at all, and may be unaware they carry the virus. Some pople may develop midl, temporary flu-like symptoms hat diasppr ater a few days or weeks following exposure. Others may have persistent swollen lymph nodes. All infected people, whether or not they have any symptoms, can transmit the virus to othrs thorugh sexul contact.

29. **What are the symptoms of advanced HIV infection and AIDS?**
Many of the symptoms of HIV infection are similar to those of other diseases, ad my be caused by non-HIV related health problems. Symptoms may include:

- extreme tiredness, sometimes combined
- swollen glands in the neck, armpits or groin;
- continued fever or night sweats;
- weight loss of more than 10% which is not due to dieting or increased physical activity.
- purple or discoloured growths on the skin or the mucous membranes (inside the mouth, anus or nasal passages);
- heavy, continual dry cough that is not from smoking or that has lasted too long to be a cold or flu;
- progressive shortness of breath;
- continuing bouts of diarrhoea;
- thrush, a thick wish coating on the tongue or in the throat which may be accompanied by sore throat;
- bruising more easily than usual;
- forgetfulness, confusion, disorientation and other signs of mental deterioration.

30. **When does HIV infection become AIDS?**
AIDS represents the most severe form of HIV infection. A person is diagnosed with AIDS when laboratory tests so severe damage to the immune system and when they have developed at least one serious illness linked with AIDS.

31. **Is there a vaccine to prevent AIDS?**
There is currently no vaccine to protect a person from HIV or AIDS. Researchers are working hard to develop a vaccine. Scientist report that this may be difficult because the virus can alter its form in the human body.

AIDS IN CHILDREN

32. **How do children get AIDS?**
The majority of HIV-infected children got the virus from their infected mothers presumably through blood exchange in the uterus or during birth. An infected mother can transmit the virus to her baby even if she has no symptoms of HIV infection or AIDS. A few children became infected from blood transfusions prior to screening of the blood supplies.

33. **What is the risk of an infected mother passing HIV to her baby?**
Studies indicate that 30-50 percent of infected mothers pass the virus to their babies. An infected mother can transmit the virus even if she herself has no symptoms.

34. **How can children be protected form HIV infection?**
All women of childbearing age should learn if they have been infected by HIV prior to considering pregnancy.

35. **Can children get HIV infection from mother's milk**
HIV antibodies have been detected in breast milk. There have been a few cases of AIDS that may have been transmitted to n infant through mother's milk. But the experts still recommend breast feeding.

36. If a child is infected with HIV. can he/she infect another child?
None of the identified cased of HIV infection in Tanzania is know or suspected to have been transmitted from one child to another in the home, school, day care or foster care setting. Even baby twins, one infected and one not, sharing nipples, toys, food, bed and playpen have not passed the virus between them.

37. Suppose my child became a regular playmate of a child with AIDS?
Casual contact, even over a long period of time, is not dangerous. In household studies, no child living with a person with HIV or AIDS has been know to contact the virus through day-t-day activities or contact.

PREVENTING THE SPREAD OF HIV

38. What is being done to prevent the spread of HIV?
Education. since there is still no cure or vaccine for AIDS, education is the most effective prevention. Educational campaigns are directed tot he general public and those who engage in high-risk behaviour, encouraging them to avoid or discontinue any practices which have been linked with the possible spread of AIDS.

39. How effective is the blood supply screening test?
All studies indicate that the HIV antibody test is highly effective in eliminating blood from the donor pool that may be infected with HIV. All blood that test positive is removed from the transfusion pool.

HOW TO REDUCE THE RISK OF HIV INFECTION

40. HIV is not transmitted from one person to another through any form of casual, non-intimate contact. HIV is transmitted through direct blood-to-blood or semen-to-blood or vaginal fluid-to-blood exchange. Direct contact with other body fluids containing blood of an infected person also may increase the risk of HIV infection.

Based on this information, there are precautions that can be taken to eliminate or reduce the risk of contracting or spreading HIV infection.

- Don't have unprotected sexual contact with any person whose past history and current health status is not know.
- Don't have unprotected sexual contact with multiple partners or with people who have had multiple partners.
- Don't have unprotected sexual contact with people known or suspected of being infected with HIV.
- Don't share toothbrushes, razors or other personal items that could have blood on them.
- People who are HIV infected, or who engage in high risk behaviour should not donate blood, plasma, body organs, or other tissue.
- People who are HIV infected should have regular medical check-ups, and take special precautions against exchanging body fluids during sexual activity.
- Women who are HIV infected should recognise that if they become pregnant, their children are at increased risk for HIV.

Appendix 6

AIDS GLOSSARY

In this glossary you will find terms you will come across when dealing with the subject of HIV infection and AIDS.

AIDS Related Complex (ARC)

A term for the combination of various early signs and symptom experienced by people with HIV infection. Some of the most common symptoms are recurrent fever, night sweats, unex plained weight loss, persistent swelling of lymph gland, chronic diarrhoea persistent oral infection

Antibodies

Substance produced by While Blood Cells in response to Antigens. They fight of bacteria, virus, fungi and substances that are dangerous for the body as causes illness. HIV antibodies produced by the body appear to be mostly ineffective in neutralising the virus. These antibodies serve as indicators for the presence of the HIV virus.

Antigen

any substance that the body regards as foreign and against which it produces an Antibody.

Antigen test.

Laboratory test done on a sample of a person's blood to detect the presence of parts of the HIV itself. This test ca indicate infection with the virus earlier than an Antibody Test.

Azidothmidine (AZT)

Also know as Zidovudine, Renhovis. This drug interferes with on of the HIV enzymes responsible for replication of the virus. The virus can not multiply so quickly whereby damage to the Immune system is slowed down. Side effects of the drug include severe anaemia and the long term effects are not known.

Bacteria

Often called germs that may also include viruses fungi and protozoa. These are single cell organisms visible only under a microscope and many can be treated with antibiotics. Many bacteria live harmlessly in the body. When the Immune System is weakened some of these harmless bacteria can cause disease (as when attached by HIV).

Bisexual

People who practice sexual activities with people of both sexes.

Carrier

A person who appears well but is capable of transmissing an infection to another person. Carriers have not outwards signs or symptoms of the disease they are carrying.

Contact tracing

Finding and talking to the partners of people who have been diagnosed as having a sexually transmitted disease (STD).

Cryptococcal Meningitis

Opportunities Infection of the brain caused by an organism called cryptococcus.

ELISA

Short for Enzyme-Linketed-Immono Sorbent-ASSAY. This is a type of test used to find anti bodies made to any organisms, including HIV.

Epdiemiology

The study of how diseases is distributed in populations groups, and the factors which influence its distribution.

False negative

Refers to the problem of a test failing to detect antibodies to HIV when the person really does have antibodies. This is very rare indeed. However, a person who has been infected my test negative because they have not yet developed antibodies as they are in a late stage of infection when hey can no longer produce antibodies.

False positive

Refers to the problem of a test indicating the presence of antibodies to HIV, when in fact the person does not have the antibodies. In such cases the person my be labelled as being infected with HIV even though they may not be.

GPA

Global Programme on AIDS, the Who division responsible for AIDS-related matters.

Herpes

There are two major types of Herpes Simples virus in Humans (Type I and II) Herpes Simplex II is sexually transmitted and causes genital herpes. Genital Herpes is a common opportunistic infection in people with AIDS.

Homosexual

People who are sexually attracted towards members of their own sex.

Incidence

The number of new cases in a survey population reported over a specified period of time.

Incubation Time

The time between infection by a disease causing organism and the onset of the signs and symptoms of the disease.

Karposis Sarcoma

A rare cancer usually appears as pink to purple painless spot on the skin. It is one of the opportunistic infection thought to be caused by a virus to which people with AIDS are more likely o get.

Mortality

The number of patients dying from a disease over a period of time.

Morbidity

The number of patients suffering from a disease over a period of time .

Monilia

A Fungal infection, also known as Thrush as Candida Albicans. People with AIDS commonly have Monilia.

Neurologica Symptoms

Some people who have been infected with HIV develop symptoms indicating mental distur bance as memory loss, damage in physical coordination.

Opportunistic Infection

Infection that are caused by organisms of which the body is normally Immune. When the Immune System is depressed or destroyed, as in AIDS, opportunistic infections can take hold.

Persistent Generalized Lymphadeno-Pathy (PGL)

One of the opportunistic infection seen in immune-suppressed people. It is cased by a very common-borne organism which is normally destroyed by Healthy Immune Systems. It is one of the most common opportunistic infection seen in people with AIDS.

Prevalence

The number of cases of a disease in a population or group at a particular point in time.

Promiscuous

When referring to sexual behaviour it means that a person does not confine sexual activity exclusively to a relationship with one person. (The term usually has a negative over tones).

Western Blot

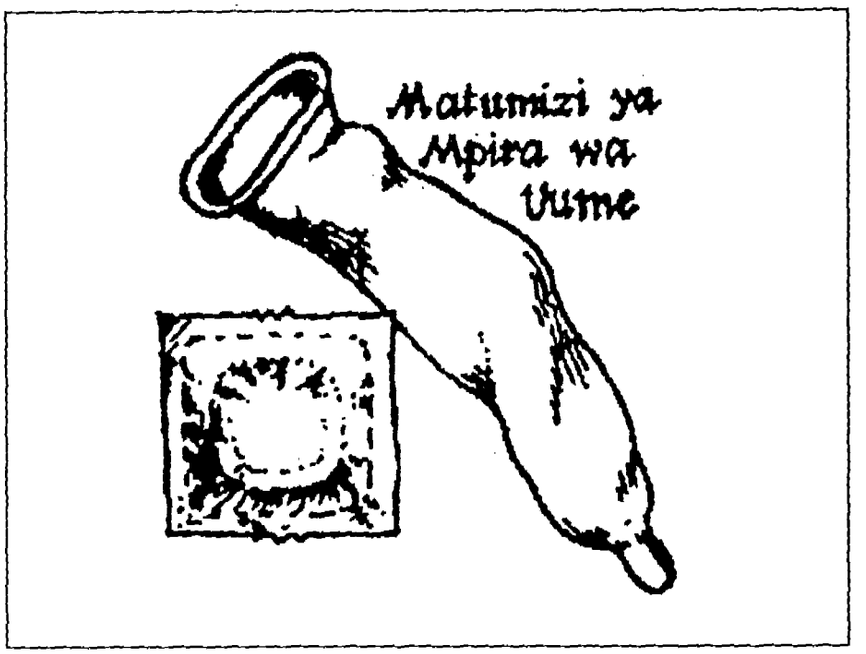
A type of test used to detect HIV antibodies more accurate, but much more expensive than ELISA.

Window period

The period of time when a person has been infected with HIV, but has not yet produced antibodies. This period is usually no longer than 3 months.

Appendix 7

INSTRUCTION ON CONDOM USE (LEAFLET)



Instruction on condom use if available at NACP and other distributorsAppendix 8

Appendix 8

THE NATIONAL AIDS CONTROL PROGRAMME
COUNSELLING REGISTRATION FORM

1. General Information

Name/Code Number.....

Age..... Sex..... Tribe.....

Nationality..... Occupation.....

Residential Area.....Town/Municipality .....

Permanent Address if any.....

.....

Martial Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Next of Kin.....

Address.....

.....

.....

II. Social Mobility

	Mobile	Not mobile
Client:	☐	☐
Spouse(s)	☐	☐
Partner(s)	☐	☐

III. Referred visit

Yes ☐ No ☐

Name of MO referring of..... Date.....

IV. Patients' visits to counsellor

Date of patients' first visit to counsellor.....

Date of informed consent for testing.....

Laboratory results

Method	Negative	Positive	Date
1. test	☐	☐	.....
2. test	☐	☐	.....

Name of Counsellor..... Signature.....

IV. Others to be involved/informed/counselled

.....

.....

Appendix 8 (contd.)

Date	Presenting problem	Cousenlling provided	Assessment of the Client	Evaluation of counselling and counsellor's performance	Date and place for next meeting	Plans for counsellor's next steps

Appendix 9

LITERATURE

LUCY MAIR
AN INTRODUCTION TO SOCIAL ANTHROPOLOGY
OXFORD UNIVERSITY PRESS 1965

WHO GPA
TRAINING MANUAL ON PSYCHOSOCIAL COUNSELLING FOR PERSONS WITH HIV INFECTION, AIDS AND RELATED DISEASES

11 Excluding Dar es Salaam, as Muhimbili Medical Center does not submit case reports to MoH.