

INTERPERSONAL COMMUNICATION AND COUNSELING FOR CLIENTS ON TUBERCULOSIS AND HIV AND AIDS



Handouts for training participants

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For further information, please contact Dr. Kateryna Gamazina, PATH Ukraine Country Program Director, at kgamazina@path.org.

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Training agenda

Day I

9:30 – 10:45

Opening

1. Opening session. Introduction of trainers and participants.
2. Review workshop objectives and agenda. Introduction to the workshop.
3. Group work and discussion.
4. Establishing ground rules.
5. Pre-training questionnaire.

10:45 – 11:00

Coffee break

11:00 – 13:00

Interpersonal communication

1. Definition of counseling. Goals and objectives.
 - Group exercise.
2. Overview of the communication process and the basic elements of effective communication.
 - Group exercise.
3. Skills for effective interpersonal communication.
4. The effects of personal attitudes and values in communication and counseling: perceptions and values.
 - Group exercises.
5. Rumors and misinformation.
 - Group exercise.
6. Verbal and nonverbal communication. Forms of verbal and nonverbal behavior used in counseling.
 - Group exercise.
7. Barriers to effective communication and common mistakes.

13:00 – 14:00

Lunch

14:00 – 17:15

The main steps of effective counseling

Energizer

1. Creating a pleasant and comfortable atmosphere for the client.
 - Privacy and confidentiality.
2. Collecting information/asking questions:
 - Types of questions.
 - Group exercises.

3. Listening actively:
 - Active listening skills.
 - Group exercises.

Coffee break

4. Providing information.
 - Group exercise.
5. Using printed materials.
6. Getting feedback, checking understanding, and encouraging clients to ask questions.
7. Helping clients make decisions.
 - Stages of awareness/behavior change adoption.
8. Making “contracts” with clients – who will do what.
9. Scheduling next visit or making a referral.
10. Meeting counseling challenges.

17:15 – 17:30

Summary for the day. Daily evaluation.

Day II

9:00 – 9:15

Recap of DAY I.
Objectives for DAY II.

Counseling on TB

9:15 – 10:45

1. Importance of effective interpersonal communication for successful treatment and care of clients with active TB. Applying principles of effective counseling.
2. Types of counseling on TB.

10:45 – 11:00

Coffee break

11:00 – 12:00

3. Demonstration of effective and poor counseling. Discussion.

12:00 – 13:00

4. Role-plays. Discussion.

13:00 – 14:00

Lunch

14:00 – 15:40

5. Group work. Presentation of group work and discussion.

15:40 – 16:00

Coffee break

16:00 – 17:40

Presentation of group work and discussion (*continued*).

17:40 – 18:00

Summary for the day. Daily evaluation

Day 3

9:00 – 9:10	Recap of DAY II and objectives for DAY III.
9:10 – 10:40	Overview of HIV Infection <ol style="list-style-type: none">1. History of the epidemic and characteristics of the HIV pathogen.2. Transmission of HIV.3. Diagnostic tests.4. Disease progression.5. TB/HIV coinfection.6. Treatment and monitoring of a patient's health.7. Stigma and discrimination.8. Privacy and confidentiality.
10:40 – 10:55	Coffee break
10:55 – 13:00	Diagnostic counseling and testing of TB clients for HIV <ol style="list-style-type: none">1. Counseling related to HIV: goals, tasks, ethical principles, and stages. Counseling messages.2. Types of counseling. Pre-test counseling. Role-plays.
13:00 – 14:00	Lunch
14:00 – 16:30	<ol style="list-style-type: none">3. Post-test counseling: negative, indeterminate, and positive results. Role-plays. Coffee break
16:30 – 17:00	<ol style="list-style-type: none">4. Ukrainian laws on HIV and AIDS.
17:00 – 17:30	<ol style="list-style-type: none">5. Burnout and stress management.
17:30 – 18:00	Summary and wrap-up <ul style="list-style-type: none">• Review and summary of key issues.• Post-training questionnaire and workshop evaluation.

Skills for effective interpersonal communication

1. Understanding of one's own values and willingness to withhold judgment about other people's values.
2. Ability to establish trust with a client.
3. Skills in verbal and nonverbal communication (maintaining direct eye contact, body posturing to show interest in client, etc.).
4. Ability to show empathy and provide encouragement.
5. Ability to observe and interpret behavior of other people.
6. Knowledge to correct misunderstandings or misinformation.
7. Skills in asking questions (using open-ended and clarifying questions that allow for full description of the client's thoughts, feelings, and concerns; avoiding leading questions).
8. Active listening skills (ability to clarify, paraphrase, and summarize the concerns of the clients).
9. Ability to encourage clients to ask questions.
10. Praising and encouraging clients for their efforts.
11. Not jumping to conclusions before the client is finished talking.
12. Ability to use language that lay people understand.
13. Skills to effectively use support materials.
14. Avoiding changing topics unnecessary.

An effective verbal communicator:

Clarifies
Listens
Encourages empathically
Acknowledges
Restates/repeats

An effective nonverbal communicator:

Relaxes
Opens up
Leans toward the other person
Establishes eye contact

Shows appropriate facial expressions

The behaviors of interpersonal communication¹

These ways of treating and thinking about others form the basis for effective interpersonal communication:

1. **Get to know others as people.** Remember their names and basic facts about them. Know their likes and dislikes, their interests and hobbies. Use this information in interacting with them.
2. **Like other people.** Will Rogers, an American philosopher, once said, "I never met a man I didn't like." Having a sincere feeling of liking, warmth, and friendliness toward those with whom one interacts provides a foundation for frictionless and effective communication.
3. **Empathize.** Empathy is the ability to put one's self in the position of other people and see problems from their point of view. It is trying to understand what leads people to speak, act, and feel as they do.
4. **Be egalitarian.** This means being unconscious of status or ignoring differences in status when interacting with others. Treat those with lower status as equals, and be dignified and self-confident when communicating with superiors. Egalitarianism requires the respect of every person as a person.
5. **Be altruistic.** Show genuine concern for the well-being and comfort of others, and a desire to be of help or service to them.
6. **Maintain a positive, cheerful outlook.** Control negative emotions and do not express them to others, but present a pleasant, cheerful outlook on life. This means one should not force others to share all of one's problems and disappointments, and one should not spend too long brooding over them.
7. **Listen attentively.** Pay attention to what others have to say, and store it away in your memory. While others are talking, do not spend all of the time thinking about what to say next. Instead, concentrate on what is being said and what it implies.
8. **Respect the beliefs and customs of others.** Do not challenge or ridicule, or show disrespect for religious, ethical, or even factual beliefs of others unless it is absolutely necessary to do so in order to accomplish one's work—and then do so in ways that are least offensive. When the customs of others differ from one's own, do not emphasize the differences, but show tolerance and respect for their right to do things as they prefer.
9. **Criticize as little as possible.** There are flaws and small defects in the speech, work, and behavior of everyone. Sometimes these defects are important and must be corrected if progress is to be made. But often the defects are minor and make no difference. Some people insist on pointing them out, possibly to demonstrate their own superiority. Do not use criticism as a weapon, but only as a constructive force to get necessary things accomplished.

¹ Adapted from *A Training Manual for Interpersonal Communication*, Social Development Center.

10. **Accept criticism and suggestions gratefully when valid and graciously even when you feel they are not.** When criticized, try to review the evidence impartially to determine whether the criticisms are justified. If you are in the wrong, admit it, thank the person for pointing out an error, and apologize if any damage has been done. Even when criticism does not seem justified, it is best to bear in mind that perceptions vary and what seems all right to you may not to someone else. In the long run, it will gain, rather than cost, status points.
11. **Be honest.** Try to tell the truth at all times, and never be deceitful. In all dealings involving material things such as money, be scrupulously honest. Once a person has been caught being deceitful or dishonest, others will be reluctant to interact with that person except in a guarded way.
12. **Have patience.** When interacting with others, it is necessary to appreciate that it may take time for them to understand what you are trying to communicate, or to agree even when they do understand. Give them the time they need, and repeat the message patiently until they understand.
13. **Think logically.** When talking with people, have the conversation follow a connected path, with what each person says following as a logical sequence to what has been said before. Learn to keep your mind "in gear" when talking, even informally.
14. **Build rapport.** Rapport is a feeling of mutual confidence, trust, and esteem that develops between people as they interact. By applying the principles above, a person can help generate rapport in every personal communication.
15. **Follow the rules of good conversation.**
 - Speak audibly and distinctly, so that all can hear.
 - Take turns in talking. Do not make long speeches.
 - Follow closely what is being said and respond to it.
 - Do not interrupt or shout over others while they are talking.
 - Use words that the listener understands. Use short sentences. State ideas clearly.
 - Be sensitive to the facial expressions and gestures (process) of other persons, as well as to what they are saying (content).

Barriers to effective interpersonal communication

Category of response	Explanation of category	Examples
False reassurance	Using false, comforting phrases in an attempt to offer reassurance.	"It will be okay." "Everything will work out."
Giving advice	Making a decision for a client. Offering personal opinions. Telling a client what to do.	"I feel you should ..." "If I were you, I would ..." "If you want to know my opinion..." "I am sure you don't want to ..."
False inferences	Making an unsubstantiated assumption about what a client means. Interpreting the client's behavior without asking for validation. Jumping to conclusions.	"What you really mean is you don't like how your doctor treated you." "You seem to be blaming your husband for getting infected with TB."
Moralizing	Expressing your own values about what is right and wrong, especially on a topic that concerns the client.	"Injecting drugs is wrong." "If you were not spending so much time with those young people with doubtful reputations, your family would not need to worry about a son with HIV and TB."
Value judgments	Conveying your approval or disapproval about the client's behavior or about what the client has said. Using words such as "good," "bad," or "nice."	"Correct. You should always do this." "That's a really good way to behave." "You are a good client."
"False polite" responses	Polite, superficial comments that do not focus on what the client is feeling or trying to say. Use of clichés.	"Isn't that nice?" "Hospital rules, you know." "Just do what the doctor says." "It's a beautiful day."
Close-ended questions	Medical worker asks "Yes" and "No" questions only.	"Are you sad?," instead of, "Tell me about your sadness."

Category of response	Explanation of category	Examples
Logical argument	We attempt to convince the other person with an appeal to facts or logic, usually without consideration of the emotional factors involved. When we are under stress or there is a conflict between others, providing logical solutions can be infuriating. Logic focuses on the facts and typically avoids feelings. When we use logic to avoid emotional involvement, we are withdrawing from another at the most inopportune moment.	
Personal story sharing	We push the other's problems aside through distraction. We switch a conversation from the other person's concerns to our own topic. Some of us divert the conversation because we lack the awareness and skills to listen effectively.	"You remind me of a friend who thought the world would end when she got TB."
Refocusing or redirecting	Refocusing the discussion away from the sources of tension, either explicitly or implicitly.	"Don't worry. You will not be fired. Your supervisor should understand that you need to take sick leave and go to the hospital. Let's talk about a different issue... " "There is no need to cry. Everything will be fine with your children. You know, yesterday, I met them near school. Your daughter ..."
Inappropriate body language or distracting actions	Using body language or actions that reject or show disinterest.	Crossing arms, shuffling papers, not making eye contact, taking phone calls, interruptions from others coming into the office, etc.
Over talks	The medical worker talks at the same time as the client.	
Interrupts	The medical worker interrupts the client when the client is talking.	
Cheering up talk		"Let's think of how wonderful your children are." "Think about how much your family loves you."

Types of questions

	Closed-ended	Open-ended	Probing	Leading
When to use:	Early in a counseling session or interview (e.g., a question used in medical history) or later, to clarify client's statements, if necessary.	As frequently as possible and whenever appropriate.	In response to a reply, such as a request for further information.	NEVER! AVOID USING LEADING QUESTIONS!
Elicits from patient:	Limited number of responses. Can usually be answered by "Yes," "No," "Sometimes," or "I don't know." Used to obtain quantifiable information.	Demands more than a simple "yes/no" response. Demands thought. Used to learn information about feelings, beliefs, practices, and knowledge. Start with "why," "what," "how."	Follows a given response, to seek more information or clarify information that has been presented. Taken out of context, or asked in a harsh tone, clarification questions can be perceived as directive.	Leads the other person towards an anticipated response. Answers the client thinks the medical provider wants to hear or ideas they might not have thought of otherwise.
Examples:	"When did you start feeling sick?" "Have you been screened for TB?" "How many times have you coughed with blood?" "Do you think you'll follow through with TB treatment?"	"What have you heard about TB?" "What kinds of physical symptoms have you been experiencing lately?" "What are some of the things a person can do to avoid infecting others with TB?"	"You said that you think that many homeless people have TB. What more can you tell me about that?" "Why do you say that it is difficult to continue your drug regimen?" "Why do you say that you think you're going to infect all your friends?"	"You do talk to your husband about TB, don't you?" "Isn't taking treatment until completed better than developing drug-resistant TB?"

Exercise to identify types of questions

Directions:

Decide if each question is open or closed, or if it is a clarification question. Mark “O” or “C” on the line in front of each question. For each closed question, propose a new formulation to transform it into an open-ended question.

1. _____ “Did your primary care physician refer you to our clinic?”
2. _____ “When your husband said that, how did you feel?”
3. _____ “When exactly did you get screened for TB?”
4. _____ “You said that you would like some information about TB. Could you tell me a bit more?”
5. _____ “Are you here because you noticed some symptoms that look like TB?”
6. _____ “What else can you tell me about TB?”
7. _____ “Of course, you know that you could spread infection around, right?”
8. _____ “Are you taking any medication?”
9. _____ “What’s been your experience since you started your medication?”
10. _____ “How can I help you understand better?”
11. _____ “Tell me, what type of social pressure are you feeling at the university?”
12. _____ “Are you comfortable here?”
13. _____ “What can you tell me about how TB is transmitted?”
14. _____ “What do you know about the symptoms and signs of TB?”

Listening habits exercise

Listening habits	Frequency					Score
	Always	Usually	Sometimes	Seldom	Never	
1. Interrupting the speaker						
2. Getting easily distracted by speaker's appearance or mannerisms (voice, pronunciation, grammar, etc.) instead of listening to what is said						
3. Paying attention only when you find the topic interesting						
4. Allowing outside distractions to interfere with your conversation (phone calls, requests from colleagues, drop-in visitors, etc.)						
5. Doing something else while listening (doing paperwork, cleaning fingernails, organizing desk, etc.)						
6. Pretending you are paying attention to the speaker when you're actually thinking of other things (grocery list, etc.)						
7. Expressing your own ideas and basically ignoring what the other person has just said						
8. Daydreaming when the speaker talks too slowly						
9. Listening mainly for flaws or errors you can point out to the speaker						
10. Thinking about what you are going to say next rather than focusing on what the speaker is saying						
TOTAL SCORE						

KEY

1. For every "Always" checked, score 2.
For every "Usually" checked, score 4.
For every "Sometimes" checked, score 6.
For every "Seldom" checked, score 8.
For every "Never" checked, score 10.
2. Add all ten of the scores to get your total score.
3. SCORE INTERPRETATION

If you scored 50 or below, you need to work hard to improve your listening skills. Choose one bad habit each day and work consciously to overcome it. You will find that being a better listener is rewarding.

If you scored 50 to 85, you have average listening behaviors and can improve your listening effectiveness with practice. You listen well under certain circumstances, but need to be more aware of when you are not listening.

If you scored 85 to 100, your listening behaviors are excellent and should yield good results. You listen very well!

Listening habits

Bad listening habits:

- Interrupts the speaker.
- Does most of the talking.
- Pretends to pay attention to the speaker when actually thinking of other things.
- Judges the speaker.
- Fills silence with talk.
- Finishes other people's sentences.
- Doesn't look at the person talking.
- Feels compelled to tell own story when speaker's message reminds listener of a personal experience.
- Gets impatient with a slow talker.
- Hears more of their inner monologue than what the speaker says.
- Feels more concerned about how the conversation benefited him (her) rather than how the conversation benefited the speaker.
- Puts words into the people's mouths.
- Decides that the message is uninteresting.
- Listens only to the words, not to the mood or the feelings.
- Repeatedly asks questions about information previously covered.
- Makes others defensive with questions.
- Is overly concerned with details.
- Uses meaningless noises as feedback.
- Gets easily distracted by speaker's appearance or mannerisms.
- Pays attention only when finding the topic interesting.
- Allows outside distractions to interfere with the discussion (phone calls, drop-in visits, etc.).
- Does something else while listening (paperwork, cleaning fingernails, etc.).
- Expresses own ideas and basically ignores what the other person has said.
- Daydreams.
- Listens mainly for flaws or errors that can be pointed out to the speaker.
- Thinks about what to say next rather than focusing on what the speaker is saying.

Good listening habits:

- Asks what the client knows about the topic and how he or she feels about it.
- Asks questions that allow client to express his or her needs and wants.
- Asks as few questions as possible that can be answered "yes" or "no" (close-ended questions). Asks questions that the client can answer in her or his own words (open-ended questions).
- Does not always accept the first answers that people give. If a client seems evasive, asks the same question in another way.
- Always polite and friendly so that the client feels more relaxed and trust can develop.
- If a client seems to feel uneasy when talking about a sensitive issue, tries to talk about something neutral for a minute or so, then gently returns to the subject.

Active listening techniques

Type	Purpose	Possible responses
Clarification	<ol style="list-style-type: none"> 1. To get at additional facts. 2. To help the person explore all sides of a problem. 	<p>"Can you clarify this?"</p> <p>"Do you mean...?"</p> <p>"Is this the problem as you see it now?"</p>
Empathizing	<ol style="list-style-type: none"> 1. To acknowledge the other person's feelings. 2. To indicate your sensitivity to the person's feelings. 	<p>"I understand how upset you must feel right now."</p> <p>"I agree that it is a very hard thing."</p> <p>"You said you feel scared. I understand how scary this is for you. How can I help?"</p>
Reflection	<ol style="list-style-type: none"> 1. To show that you understand how the other feels about what he or she is saying. 2. To give the patient an opportunity to correct us. 	<p>"You feel that..."</p> <p>"It was surprising to you that..."</p> <p>"You felt you didn't get a fair hearing."</p>
Paraphrasing	<ol style="list-style-type: none"> 1. To check our interpretation of what was being said by the patient. 2. To show you are listening and that you understand what the other has said. 	<p>"As I understand it, you want to go home as soon as possible. I understand if you are feeling tired of treatment and you are ready to go home. You have been very patient, and you only have two weeks left at the clinic."</p> <p>"Is this what you have decided to do...? and the reasons are...?"</p>
Praise and encouragement	<ol style="list-style-type: none"> 1. To make people feel better about themselves. 2. To build a person's self-esteem and confidence, empowering him (her) to meet their goals. 	<p>"I appreciate that you are sharing your feelings with me. A lot of people are just as scared as you are. It's important to talk about that. I will always be glad to help."</p> <p>"Good question. I am glad that you asked."</p> <p>"It is great that you came here to get more information."</p>
Summarizing	<ol style="list-style-type: none"> 1. To bring the discussion into focus in terms of a summary. 2. To repeat the most important issue. 	<p>"These are the key ideas you have expressed..."</p> <p>"We agreed that..."</p>

Name: _____
 Person observed: _____

Active listening Checklist

Observe the listening skills of your partner. Whenever she or he exhibits an aspect of active listening, check the "yes" column. When a principle of active listening is ignored or violated, check the "no" column.

Element or behavior observed:	No	Yes
1. Used "body language" to communicate interest (such as leaning forward).		
2. Used body language to show understanding (nodding their head).		
3. Used encouraging words/phrases ("I see," "Uh-huh," "yes," etc.) to encourage free flow of conversation.		
4. Maintained eye contact much of the time.		
5. Used open-ended questions to encourage the other person to expand fully on his or her feelings.		
6. Listened quietly, refraining from interrupting, taking over, etc.		
7. Sought clarification when statements were not totally clear.		
8. Empathized to acknowledge the other person's feelings.		
9. Used appropriate words to reflect and show that the client's feelings are understood.		
10. Paraphrased the other person's responses to encourage communication.		
11. Summarized various points in the conversation.		

Other comments or observations:

How to use different types of visual aids

How to use booklets or leaflets

Booklets or leaflets are designed to reinforce or support verbal messages. The materials are not a substitute for good interpersonal communication skills, but, if used properly, they strengthen the messages you give to clients. The following are suggestions on how to use booklets and leaflets.

1. Go through each page of the booklet with the client. This will give you a chance to both show and talk about the content and answer any questions that the client may have.
2. If there is a picture, point to it, not the text that appears on the page. This will help the client remember what the illustrations represent. This is especially important for clients who do not read very well.
3. Observe the client to see if he or she looks puzzled. If so, encourage him or her to ask questions or talk about any concerns. Discussion helps establish a good relationship and builds trust between you and the client.
4. After you have explained the information, ask the client to repeat it in his or her own words. That way you will know if the client has understood the important messages.
5. Give the client the booklet to keep and suggest that he or she share it with others.

How to use posters

Display motivational posters in places of high visibility, such as clinics, schools, theaters, small shops, and bus and railway stations. Ask permission first so that your poster is not ripped down and wasted. Educational posters can be placed in the same places if appropriate. Think about what the poster is meant to do and who will see it. You can also use posters to stimulate discussion with a group (for example, in a classroom at school).

How to use flip charts

A flip chart is made of a number of stiff pages, usually of pictures, that are bound together at the top. It can be stood up on a table or held in someone's hand. Flip charts can help you remember important things to say. They can help you explain difficult ideas and give clear instructions. You can use a flip chart with a couple, one client, or a group. It is very useful for leading group discussions.

When using the flip chart with a group, be sure to stand where the whole group can see the flip chart. ALWAYS FACE THE AUDIENCE. Hold the flip chart so that the group can see it. Move around the room with the flip chart if the whole group cannot see at one time.

Some specific suggestions to follow when **using a flip chart**:

1. Set the flip chart facing the people and, if possible, in a place higher than their heads. Then everyone can see it.
2. Stand beside the flip chart so that everyone can see it. Do not stand in front of it. Face the group.
3. If the flip chart has text, use it as a guide, but familiarize yourself with the content so that you are not dependent on the text.
4. Know what you will say before you start. Then you can look at the group while you talk. Do not talk to the flip chart or your notes. Talk to the clients.
5. If possible, write notes on the backs of the pages. These notes can remind you of what you want to say.
6. Point to the pictures while you talk. Do not point to the words (the text). Ask questions about the pictures. Ask the group if they have any other questions.

Making decisions

Types of decisions:

- **Decision by default:** Let something happen through inaction.
- **Intuitive, snap decision:** It feels right, and it is immediate.
- **Decision in reaction:** "You did this to me so I'll do this to you"—often made in anger or haste.
- **Deferred decision:** Shifted to another person, letting someone else take responsibility.
- **Deliberate decision:** Thoughtful, considering all options.

Motives affecting decision-making

- **Physical reactions:** Based on bodily sensation, such as pain, discomfort, or pleasure. Usually, people will avoid behavior that brings pain, or they will engage in behavior that brings pleasure.
- **Emotions:** Based on feelings or attitudes. People respond to a situation on a subjective level.
- **Rational/thought:** Based on knowledge and belief. People weigh the information they have, and carefully consider the situation, its consequences, and their options.
- **Practicality:** Based on individual skills and ability to act. A person assesses his/her competence and confidence in her/his ability to act.
- **Interpersonal relationships:** Based on influence of social networks. Person-to-person relationships affect individual actions.
- **Structures:** Based on the social and economic context. The environment may be conducive, supportive, or critical of a particular behavior.

Difficulties in decision-making and suggestions for coping with them²

Decision-making forms a continuing pattern of relationships among individuals and groups: a pattern in which each person has some influence and some stake. Interpersonal relations are extremely important in decision-making. Self-esteem also plays an important role for young people, in particular. Some difficulties in decision-making result from the following factors:

Fear of consequences: Sometimes the possible outcomes of an impending decision may create fear among some individuals, bringing about confusion or disagreement with other parties. Frank acknowledgment of these fears helps young people work through their concerns and, when done constructively, helps heal divisions between people.

Conflicting loyalties: When one person is a member of a number of groups, that person's decision-making power may be affected by his or her feelings of loyalty to competing parties. Again, if these conflicts are brought out into the open without threatening the individual, the person may be better able to resolve them. People may need help thinking through the advantages or disadvantages of choosing or not choosing a side.

Interpersonal conflict: When personal differences occur between people, they may naturally feel affection or dislike toward others, which can then interfere with sound decision-making. Often a person who is not involved in the interpersonal conflict can bring the real problem into the open.

Hidden agenda: One person may try to get another person to make a certain decision for reasons that he or she does not share. It is important for people to be open about their motivations so that everyone involved can make informed decisions.

Peer pressure: Social group leaders may hinder good decision-making if they pressure peers to make decisions on issues too soon. Helping people practice healthy peer counseling and active listening creates an environment in which people can express their individuality and opinions.

Clash of interests: Sometimes different groups or individuals have opposing interests—such as women wanting to feel safe and men wanting to feel in control. These types of conflicts often involve issues of power, resources, or rights. People need to respect their peers' needs and interests, even when they are different from their own.

² Adapted from Training for Transformation & Basic Reader in Human Relations Training.

Meeting counseling challenges³

Here are some challenges that medical providers often face, with suggestions about meeting them:

1. The client is silent.

- If the client is silent at the start of the meeting, gently call attention to the silence. You could say, “I can see that it is difficult to talk. It’s often that way for new clients. I wonder if you are feeling a little anxious?” Look at the client and use body language that shows empathy and interest. Wait for the client to answer.
- During discussion, silence can be okay. Sometimes the client is thinking or deciding how to express feelings or thoughts. Give the client time to think.

2. The client cries.

- A client may cry for different reasons—to express sadness, to win sympathy, out of stress or nervousness, or to stop further discussion. Do not assume why the client is crying.
- Wait for a while, and, if crying continues, say that it is all right to cry. It is a natural reaction. This permits the client to express the reasons for crying. It is okay to ask the reasons gently.

3. The medical provider cannot see a solution to the client’s problem.

Medical providers may feel anxious if they are not sure what to advise. They are the medical experts but do not have to solve every problem for the clients. Express understanding. Sometimes this is what the client really wants. Also, suggest others who could help.

4. The medical provider does not know the answer to a client’s question.

Say honestly and openly that you do not know the answer but together you can find out. Check with a supervisor, a knowledgeable coworker, or reference materials, and give the client the accurate answer.

5. The medical provider makes a mistake.

- Correct the mistake and say you are sorry. It is important to be accurate. It is not important to look perfect. Admitting a mistake shows respect for the client.
- Be honest. The more honestly you express your own feelings when appropriate (without revealing your personal life), the easier it is for the client to do the same.

³ Adopted from Rinehart, W., Rudy, S., and Drennan, M. *GATHER Guide to Counseling*. Population Reports, Series J, No. 48, Baltimore, Johns Hopkins University school of Public Health, Population Information Program, December 1998.

6. Medical provider and client already know each other.

- Emphasize confidentiality and ensure privacy.
- If the client wishes, arrange for another medical provider.

7. The client asks a personal question.

- In general, try not to talk about yourself. It takes attention away from the patient.
- You do not have to answer personal questions. The relationship between client and medical provider is a professional one, not a social one.
- It can help to talk about your own experience if you wish. Or you can describe what happened to someone else, without using names or identifying them as other clients.
- Sometimes the client asks if the medical provider has the same problem. It is best not to say yes or no. Instead, you can say something such as, "I am familiar with that kind of situation. Please tell me more."

8. The client wants the medical provider to make the decision.

- This client may actually be asking for help. You can ask questions such as these: "You seem to be having trouble reaching a decision. Perhaps you are not quite ready? Would you like to discuss this further? Do you need more information? More time to think? Would you like to talk this over with someone else – perhaps your spouse or your parents?"
- You can say, "I can answer your questions and help you think about your choices, but you know your own life best. The best decisions will be the decisions you make yourself."

Check your counseling skills⁴

GREET — Did you:

- ___ Welcome each client on arrival?
- ___ Meet in a comfortable, private place?
- ___ Assure the client of confidentiality?
- ___ Express caring, interest, and acceptance by words and gestures throughout the meeting?
- ___ Explain what to expect?

ASK — Did you:

- ___ Ask the client's reason for the visit?
- ___ Encourage the client to do most of the talking?
- ___ Ask mostly open questions?
- ___ Pay attention to *what* the client said and *how* it was said, and follow up with more questions?
- ___ Put yourself in the client's shoes—understand without expressing criticism or judgment?
- ___ Ask about feelings?
- ___ Ask the client's preferences?

TELL — Did you:

- ___ Start discussion with the client's preference?
- ___ Tailor and personalize information?
- ___ Give information important to the client's decision?
- ___ Avoid "information overload"?
- ___ Use words familiar to the client?
- ___ Use samples, drawings, or other counseling aids?

HELP — Did you:

- ___ Let the client know that the decision is hers (or his)?
- ___ Help the client identify the full range of possible choices?
- ___ Help the client think how the various choices would affect her or his own life?
- ___ Advise without controlling?
- ___ Let the client decide?
- ___ Ask the client to state her or his decision?
- ___ Reflect the client's decision to confirm it?
- ___ Make sure the client's choice is based on accurate understanding?

EXPLAIN — Did you:

- ___ Explain how to use medication? Effectiveness? Side effects? Specific medical reasons to return?
- ___ Check the client's understanding?
- ___ Ask for any questions?
- ___ Explain any printed instructions and give them to the client?

RETURN — Did you:

- ___ Plan the next visit, if needed?
- ___ Invite the client to come back any time, for any reason?
- ___ Refer the client for any care you cannot give?

⁴ Adopted from Rinehart, W., Rudy, S., and Drennan, M. *GATHER Guide to Counseling*. Population Reports, Series J, No. 48, Baltimore, Johns Hopkins University school of Public Health, Population Information Program, December 1998.

From Cough to Cure: A Path of Ideal Behaviors in Tuberculosis Control

B A R R I E R S

LEVELS						
Individual & Group	<ul style="list-style-type: none"> * Poor knowledge of TB symptoms * Poor knowledge of TB care and cure * Stigma related to TB diagnosis * Low risk preception 	<ul style="list-style-type: none"> * Misperception of costs * Preference for non-DOTS health services * Attitude about health services * Stigma * Social Norm 	<ul style="list-style-type: none"> * Poor knowledge of diagnostic steps * Expectations about medical services (get meds not tests) 	<ul style="list-style-type: none"> * Poor knowledge of length of treatment * Stigma 	<ul style="list-style-type: none"> * Poor knowledge of length of treatment * Stigma 	<ul style="list-style-type: none"> * Poor knowledge of length of treatment * Stigma
IDEAL BEHAVIOR	Seek Care	Go to DOTS	Complete Diagnosis	Begin Treatment	Continue Treatment & follow-up smears	Complete Treatment & final smear
System		<ul style="list-style-type: none"> * Time, cost, distance to DOTS facility * Lack of linkages between DOTS and other providers (non-DOTs & HIV care) * Missed diagnosis and / or lack of referral by non-DOTS providers 	<ul style="list-style-type: none"> * Providers' poor knowledge of correct procedures * Providers' poor inter-personal communication * Lack of resources, including human resources * Poor quality of services (hours, wait-time) * Time, cost and distance 	<ul style="list-style-type: none"> * Time, cost, distance to DOTS facility * Poor quality of services * Health providers fail to give adequate information * Lack of medications 	<ul style="list-style-type: none"> * Time, cost, distance to DOTS facility * Poor quality of services * Health providers fail to give adequate information * Lack of medications 	<ul style="list-style-type: none"> * Time, cost, distance to DOTS facility * Poor quality of services * Health providers fail to give adequate information * Lack of medications

The Cough to Cure Pathway was developed as a diagnostic and planning tool by the Academy for Educational Development.

Client-centered counseling for TB patients

GREET	1. Create a pleasant and comfortable atmosphere: <ul style="list-style-type: none"> • Assure privacy and confidentiality • Be positive and encouraging • Use a friendly tone of voice and attentive body language to convey warmth, interest, and respect
ASK	2. Collect information <ul style="list-style-type: none"> • Focus on the patient • Explore the client's lifestyle, life stage, life goals, and preferences • Ask open-ended questions 3. Listen actively <ul style="list-style-type: none"> • Clarify • Empathize • Reflect • Paraphrase • Summarize • Respond to the patient's concerns, including rumors, respectfully and constructively
TELL	4. Provide information <ul style="list-style-type: none"> • Communicate medical information clearly • Be brief • Use simple, non-technical language • Do not give irrelevant information or too much information at once • Encourage questions and make time to respond to them • Check that the patient understands information that you tell him or her • Know your own biases about methods and treatments and compensate for them • Use memory and job aids 5. Use printed materials to guide and inform the interaction
HELP	6. Get feedback and check the patient's understanding 7. Help the patient make a decision <ul style="list-style-type: none"> • Let the patient know that she or he has options and that the choice of how to proceed belongs to him or her • Offer to help the patient think through the options • Ask the patient to confirm his or her decision • Help the returning patient weigh the pros and cons of continuing treatment
EXPLAIN	8. Make a "contract" with the patient – agree on who will do what <ul style="list-style-type: none"> • Help the patient plan how to carry out his or her decision • If possible, give the patient pretested informational materials that she or he can consult at home • Invite the patient to call or return if she or he has questions, doubts, or concerns • Schedule the next visit, if appropriate
RETURN/REFER	9. Provide information about the next visit or refer to any care you cannot give

The Patients' Charter for Tuberculosis Care⁵

Patients' rights and responsibilities

Patients' rights

You have the right to:

Care

- The right to free and equitable access to tuberculosis care, from diagnosis through treatment completion, regardless of resources, race, gender, age, language, legal status, religious beliefs, sexual orientation, culture, or having another illness.
- The right to receive medical advice and treatment which fully meets the new *International Standards for Tuberculosis Care*, centering on patient needs, including those with multidrug-resistant tuberculosis (MDR-TB) or tuberculosis–human immunodeficiency virus (HIV) coinfections and preventative treatment for young children and others considered to be at high risk.
- The right to benefit from proactive health sector community outreach, education, and prevention campaigns as part of comprehensive care programs.

Dignity

- The right to be treated with respect and dignity, including the delivery of services without stigma, prejudice, or discrimination by health providers and authorities.
- The right to quality health care in a dignified environment, with moral support from family, friends, and the community.

Information

- The right to information about what health care services are available for tuberculosis and what responsibilities, engagements, and direct or indirect costs are involved.
- The right to receive a timely, concise, and clear description of the medical condition, with diagnosis, prognosis (an opinion as to the likely future course of the illness), and treatment proposed, with communication of common risks and appropriate alternatives.
- The right to know the names and dosages of any medication or intervention to be prescribed, its normal actions and potential side-effects, and its possible impact on other conditions or treatments.
- The right of access to medical information which relates to the patient's condition and treatment and to a copy of the medical record if requested by the patient or a person authorized by the patient.
- The right to meet, share experiences with peers and other patients, and to voluntary counseling at any time from diagnosis through treatment completion.

⁵ Published by the World Care Council, http://www.who.int/tb/publications/2006/patients_charter.pdf, November 2008.

Choice

- The right to a second medical opinion, with access to previous medical records.
- The right to accept or refuse surgical interventions if chemotherapy is possible and to be informed of the likely medical and statutory consequences within the context of a communicable disease.
- The right to choose whether or not to take part in research programs without compromising care.

Confidence

- The right to have personal privacy, dignity, religious beliefs, and culture respected.
- The right to have information relating to the medical condition kept confidential and released to other authorities contingent upon the patient's consent.

Justice

- The right to make a complaint through channels provided for this purpose by the health authority and to have any complaint dealt with promptly and fairly.
- The right to appeal to a higher authority if the above is not respected and to be informed in writing of the outcome.

Organization

- The right to join, or to establish, organizations of people with or affected by tuberculosis and to seek support for the development of these clubs and community-based associations through the health providers, authorities, and civil society.
- The right to participate as “stakeholders” in the development, implementation, monitoring, and evaluation of tuberculosis policies and programs with local, national, and international health authorities.

Security

- The right to job security after diagnosis or appropriate rehabilitation upon completion of treatment.
- The right to nutritional security or food supplements if needed to meet treatment requirements.

Patients' responsibilities

You have the responsibility to:

Share information

- The responsibility to provide the health care giver as much information as possible about present health, past illnesses, any allergies, and any other relevant details.
- The responsibility to provide information to the health provider about contacts with immediate family, friends, and others who may be vulnerable to tuberculosis or may have been infected by contact.

Follow treatment

- The responsibility to follow the prescribed and agreed treatment plan and to conscientiously comply with the instructions given to protect the patient's health, and that of others.
- The responsibility to inform the health provider of any difficulties or problems with following treatment or if any part of the treatment is not clearly understood.

Contribute to community health

- The responsibility to contribute to community well-being by encouraging others to seek medical advice if they exhibit the symptoms of tuberculosis.
- The responsibility to show consideration for the rights of other patients and health care providers, understanding that this is the dignified basis and respectful foundation of the tuberculosis community.

Show solidarity

- The moral responsibility of showing solidarity with other patients, marching together towards cure.
- The moral responsibility to share information and knowledge gained during treatment and to pass this expertise to others in the community, making empowerment contagious.
- The moral responsibility to join in efforts to make the community tuberculosis free.

About *The Charter*

The Patients' Charter for Tuberculosis Care (The Charter) outlines the rights and responsibilities of people with TB. It empowers people with the disease and their communities through knowledge of the disease. Initiated and developed by patients from around the world, *The Charter* makes the relationship with health care providers a mutually beneficial one.

The Charter sets out the ways in which patients, communities, health care providers, both private and public institutions, and governments can work together as partners in a positive and open relationship, to improve standards of TB care and enhance the effectiveness of the health care process. It allows all parties to be held more accountable to each other, fostering mutual interaction and a "positive partnership."

Developed in tandem with the *International Standards for Tuberculosis Care* (<http://www.worldcarecouncil.org/>) to promote a "patient-centered" approach, *The Charter* bears in mind the principles on health and human rights of the United Nations, UNESCO, WHO, Council of Europe, as well as other local and national charters and conventions, including the United Nations CESC General Comment 14 on the right to health, WHO Ottawa Charter on health promotion, The Council of Europe Convention for the Protection of Human Rights and Dignity (biology and medicine), and the UNESCO Universal Draft Declaration on Bioethics and Human Rights (available at <http://www.worldcarecouncil.org/>).

The Patients' Charter for Tuberculosis Care practices the principle of Greater Involvement of People with Tuberculosis (GIPT). This affirms that the empowerment of people with the disease is the catalyst for effective collaboration with health providers and authorities and is essential to victory in the fight to stop tuberculosis. *The Charter*, the first global "patient powered" standard for care, is a cooperative tool, forged from common cause, for the entire tuberculosis community.

Phases of counseling patients on TB

Objectives	Key counseling actions	Recommended questions	Key messages
Pre-diagnosis counseling (when a client first comes in for screening)			
<ul style="list-style-type: none"> To develop mutual trust and respect between the client and provider. To collect necessary medical and psychosocial information about a client. To provide information about diagnostic tests and to support the client's decision to be tested. To provide basic information on TB and reassure the client that TB is curable. To help cope with the stress of being tested and a possible diagnosis of TB. To emphasize the importance of the next visit and to schedule it. To motivate the client to take additional tests, if needed. To provide the client with basic information and skills to protect household members and contacts from infection prior to starting treatment. 	<ol style="list-style-type: none"> Greetings and introductions. Clinical evaluation: history taking, review of signs and symptoms. Discussion of potential diagnosis and explanation of needed diagnostic tests. Addressing questions and concerns. Planning for diagnostic tests and follow-up of results. 	<ul style="list-style-type: none"> How do you prefer to be addressed? What brought you to the clinic today? When did you first feel unwell? Tell me more about how you feel now. Since becoming ill, what have you done to feel better? What have you heard about TB? TB has a number of symptoms that could also be caused by other illnesses. These include cough of more than two weeks, coughing up blood, unexplained weight loss, lack of appetite, fever, night sweats, chest pain, difficulty breathing, and fatigue. Tell me about any of these symptoms or other symptoms you have experienced. How long have you been coughing? What kind of a cough do you have (e.g., dry, productive, with blood)? 	<ol style="list-style-type: none"> Your symptoms suggest that you may have TB, but we cannot be sure until we do some laboratory tests of your sputum. It is very important to conduct your sputum test so we know whether or not you have TB. These tests are provided to you free of charge. To do the tests, we will collect and test several samples of your sputum and look at them under the microscope. You can expect to get your results in ____ days. A nurse will instruct you on how to collect your sputum. You will give us one specimen now, and we will ask you to collect specimens at home and then bring them to the clinic for testing. TB is a disease caused by bacteria (germs). TB is spread from one person to another through the air. It usually affects your lungs, but may also cause illness in other parts of your body. TB is a serious illness that must be treated, but it is important to know that it can be completely cured by taking a combination of medicines. Typical symptoms of TB are persistent cough for more than 2 or 3 weeks; fever for more than 7 days; shortness of breath and pain in chest; decrease in appetite, sudden or unexpected weight loss; fatigue; sweating at night; and productive cough with blood in

Objectives	Key counseling actions	Recommended questions	Key messages
		<ul style="list-style-type: none"> What questions about TB or your health in general can I help answer before you leave today? 	<p>sputum.</p> <p>6. Early diagnosis of tuberculosis is very important because early treatment can prevent you from getting very ill and will help prevent spread of your illness to your family and friends.</p> <p>7. If you do have TB, there is a chance you can spread it to other people. While you are waiting for your test results, there are four things you can do to reduce the chances of spreading TB to your family or friends:</p> <ul style="list-style-type: none"> The best thing to do is to cover your mouth with a handkerchief or tissue if you cough or sneeze. If you can keep the windows open in your house to allow air to circulate, that will also help. If possible, sleeping in a separate room will help reduce the chances of spreading TB to others. Finally, avoid close contact with young children and other people who may have weak immune systems as they are more vulnerable to illness. <p>8. TB cannot be spread by sharing food, eating utensils, or clothes. It is not transmitted through physical (e.g., shaking hands) or sexual contact.</p>
<p style="text-align: center;">Initial counseling (for a newly diagnosed TB patient in the intensive phase of treatment)</p>			
<ul style="list-style-type: none"> To inform the client about test results and explain what they mean in clear terms. To help clients cope with emotional stress and 	<ol style="list-style-type: none"> Greeting and introductions. Explanation of the TB diagnosis. Helping the patient to cope with stress. 	<ul style="list-style-type: none"> What problems will your illness cause you? What concerns or fears do you have about being diagnosed with TB? What concerns or questions 	<ol style="list-style-type: none"> Anybody can get TB. TB is caused by a germ (<i>Mycobacterium tuberculosis</i>) that is transmitted through the air when a person who is sick with TB coughs or sneezes. A healthy person can get infected from breathing in those germs and might develop active TB.

Objectives	Key counseling actions	Recommended questions	Key messages
<p>uncertainty.</p> <ul style="list-style-type: none"> • To check and reinforce the client's existing knowledge of TB. • To provide accurate, simple information on TB and TB treatment and correct client misperceptions about TB. • To motivate the client to start and complete treatment. • To identify and enlist resources (e.g., people, services) that can support the client through treatment. • To identify and address potential barriers to treatment adherence and cure. • To help the client make decisions about his or her TB treatment. • To strengthen the mutual trust and respect between client and provider as a critical element for treatment adherence and cure. • To make an agreement or "contract" with the client to ensure follow-up. • To provide appropriate referrals (including for 	<ol style="list-style-type: none"> 3. Understanding patient's perceptions about TB and concerns about being diagnosed with TB. 4. Explanation of the following: <ul style="list-style-type: none"> • TB and its symptoms, emphasizing that TB is a curable disease; • TB treatment regimen: duration, intensive phase of treatment, continuation phase of treatment; • drugs and doses used to treat TB; • possible side effects of medication and what to do; • the importance of taking medications regularly for the full course of treatment, and options available for DOT/treatment support; • how to prevent spreading TB to others and the importance of screening family members for TB. 	<p>do you have about TB treatment?</p> <ul style="list-style-type: none"> • Taking TB treatment for the full six months is important, but it can be difficult. What family member or friend can help encourage you to keep taking your medicine for the whole course of treatment? • What will be difficult for you about taking this treatment? • What else will help you complete your treatment and be cured? • How do you feel about the TB treatment plan I have described? Is it practical for you? • Tell me about your household. Who lives with you? Are any of them sick with a cough or other symptoms? • How will your family or friends feel about your TB? • Tell me about your work. Will having TB cause you any difficulties with your work? • Tell me what you think causes TB. • Why do you think you got sick? • What does TB do to your body? • How severe do you feel your 	<ol style="list-style-type: none"> 3. TB usually affects the lungs, but may affect other parts of the body as well. It is a serious disease, but it can be cured with a combination of medications. Without correct and complete treatment, a patient can become very ill and can die from TB. 4. TB treatment is free of charge. 5. Taking the medicines as prescribed will help you feel better quickly and will also help you prevent spreading disease to others. It is important to take all the medicines as directed to keep the TB germs from developing resistance to the drugs, which then requires a much more complicated and longer treatment. 6. Taking TB treatment for six to eight months can be difficult. It is very important to do so to avoid getting sick again. To help patients take treatment properly and get cured, we provide you with treatment support. You have several options for how and where you will receive your medicines, and you can choose the best option for you (assuming this is true). 7. Anti-TB drugs can have side effects in some people. Most side effects are minor and disappear over time. We will review the serious side effects to watch for that you should report to your provider immediately so they can be treated properly. 8. Tell us if you plan to move, so we can arrange that you continue treatment without interruptions. 9. The same type of sputum tests that were used to diagnose your TB will be repeated to monitor improvement in your condition. They will be repeated at set intervals as needed and at the end of treatment.

Objectives	Key counseling actions	Recommended questions	Key messages
DCT).	5. Assessment of available supports and potential barriers to treatment adherence and completion. 6. Patient concerns about the treatment and follow-up care. 7. Next steps, referrals, and schedule for next visit.	illness is? • What are the most important results you hope to receive from this treatment? What times of the day can you come to the clinic?	10. Based on the patient's specific situation, the medical provider should explain how long the treatment will be, frequency of visits, and where to go for treatment. 11. We will be careful about keeping your records in a secure location and not revealing them to others (assuming this is true). 12. You can prevent the spread of TB to others by: a) taking medicines that are prescribed by your doctor according to the recommended schedule; b) covering your mouth when you cough or sneeze; c) opening windows to allow fresh air into your home; d) sleeping in a separate room if possible for the first stage of treatment; e) avoiding close contact with young children, the elderly, or other people with weakened immune systems in the first stage of your treatment. 13. All members of your family and close contacts need to be examined and treated if needed.
Ongoing counseling (for a TB patient during the continuation phase of treatment)			
• To check whether the patient is taking medications correctly and help the patient address any barriers to adherence. • To emphasize the importance of treatment continuation and completion even when the	1. Greetings. 2. Review of how the patient is feeling, any problems, and concerns. 3. Review of clinical progress based on any test results. 4. Review of	• How are you feeling? • Have you had any problems? • Did you experience any side effects? • What concerns or questions do you have about TB treatment? • How do you feel about the	1. To be cured, you must continue taking medicines for the entire course of treatment even if you feel better and don't have symptoms anymore. If you do not take all the drugs, you could become ill again or develop drug-resistant TB. 2. Don't forget to inform your medical provider if you plan to travel or move to another area. We will make arrangements for you to continue treatment.

Objectives	Key counseling actions	Recommended questions	Key messages
<p>patient feels much better.</p> <ul style="list-style-type: none"> • To provide emotional support to the patient. • To check for possible side effects. • To strengthen the patient's motivation to continue and complete the treatment. 	<p>medications and how to take them. Discussion of any side effects.</p> <p>5. Assessment of adherence and reinforcement of messages about continuing treatment to cure.</p> <p>6. Follow-up on any referrals made.</p>	<p>TB treatment? Is there anything difficult for you?</p> <ul style="list-style-type: none"> • In your opinion, why it is important to complete the entire course of treatment? • What helps you to adhere to the regimen? OR What prevents you from receiving regular treatment? • Who could support and approve your pursuit to accomplish the treatment? 	<p>3. It is important to repeat the sputum tests to check if TB germs are still present and whether your condition is improved.</p> <p>4. If TB is not detected, your condition is improving and you are no longer infectious and won't spread TB to others; however, you must continue the treatment until the end or you could become ill again.</p> <p>5. If TB is detected, you may still be infectious, and we will continue to monitor you more frequently to see if your treatment must be changed.</p>

HIV risk continuum⁶

Practice	Risk	Notes
Abstinence	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Masturbation	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Unprotected sex with a monogamous, uninfected partner	No risk	Having unprotected sex in a monogamous relationship carries no risk as long as both partners are uninfected. However, it is often difficult to know if a partner is truly monogamous and uninfected.
Sharing eating utensils with an HIV-positive person	No risk	Studies have found that saliva does not contain enough virus to allow for HIV transmission.
Shaking hands with an HIV-positive person	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Sitting on a public toilet seat	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Getting bitten by a mosquito	No risk	Studies have found that mosquitoes do not transmit HIV between people.
Massage	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Hugging an HIV-positive person	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Helping someone with a nosebleed	No risk	If the skin on your hands is intact, then there is no risk for transmission.
Taking a blood pressure without gloves	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Performing an abdominal exam without gloves	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Getting a client's blood on your hands	No risk	If the skin on your hands is intact, then there is no risk for transmission.
Cleaning up a blood spill wearing latex gloves	No risk	The gloves offer protection from the possible exchange of body fluids.
Performing a cesarean section delivery without gloves	Low risk/ No risk	In the absence of sharps injury, the risk of HIV transmission is very low.
Sexual stimulation of another's genitals using hands	Low risk/ No risk	Risk is very low if there are no cuts or broken skin on hands, especially if there is no contact with secretions, semen, or menstrual blood.
Oral sex on a man (fellatio) with a condom	Low risk/ No risk	Risk is very low if the condom is used correctly. However, some STIs (e.g., herpes) can be transmitted through contact with skin not covered by the condom.

⁶ Adapted from *Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers*. New York: EngenderHealth, 2004.

Practice	Risk	Notes
Vaginal sex with a condom	Low risk	Risk is very low if the condom is used correctly. However, some STIs (e.g., herpes) can be transmitted through contact with skin not covered by the condom.
Vaginal sex with multiple partners; condom use every time	Low risk	Multiple partners increase risk; however, correct and consistent condom use lowers risk. A new condom must be used with every partner and for every sexual act.
Cleaning up a blood spill without wearing latex gloves	Low risk	Risk is higher if hands have cuts or rashes.
Getting blood from a client splashed in your eye	Low risk	The risk of transmission is approximately 1 in 1,000.
Getting blood from a client splashed in your mouth	Low risk	The risk of transmission is approximately 1 in 1,000.
Performing a delivery without wearing latex gloves	Low risk	The risk of transmission is low as long as the skin of the hands is intact.
Performing a pelvic exam during labor without wearing gloves	Low risk	The risk of transmission is low as long as the skin is intact. However, meticulous hand-washing is required to minimize infection transmission.
Getting a client's blood on your hand that has a recent cut on it	Low risk	Depending on the size and depth of the cut, the amount of blood, and the amount of virus in the blood. Few or no documented cases of this mode of transmission.
Getting a client's blood on your hand that has a rash on it	Low risk	Depending on the severity of the rash, the amount of blood, and amount of virus in the blood. Few or no documented cases of this mode of transmission.
Recapping a used needle	Low risk	Although the risk of injury is high, the actual risk of infection is low (approximately 1 in 300).
Sticking yourself with a used needle in the lab	Low risk/ possibly medium risk	The approximate risk of transmission is 1 in 300. Risk may vary depending on depth of injury and source patient's stage of illness.
Anal sex with a condom	Low risk/ possibly medium risk	Risk of condom breakage is greater than for vaginal sex. Some STIs (e.g., herpes) can be transmitted though contact with skin not covered by the condom.
Oral sex on a man without a condom	Low risk/ possibly medium risk	HIV can be transmitted through oral sex, though the risk is very low unless there are cuts or sores in the mouth. The risk of transmission is lower if no semen enters the mouth.
Oral sex on a woman (cunnilingus)	Low risk/ possibly medium risk	HIV can be transmitted through oral sex, though the risk is very low unless there are cuts or sores in the mouth.

Practice	Risk	Notes
Unprotected vaginal sex with withdrawal prior to ejaculation	High risk	HIV can be present in pre-ejaculate, and therefore, risk of transmission is high; however, withdrawal may reduce risk of HIV transmission somewhat. Unlikely to reduce risk of other sexually transmitted infections.
Vaginal sex without a condom	High risk	One of the highest risk activities. Receptive partner is at greater risk.
Anal sex without a condom	High risk	One of the highest risk activities. Receptive partner is at greater risk.
Reusing sharp instruments to cut skin (e.g., scalpels, instruments used for tattoos)	High risk	If these instruments have been used on others and are not properly processed, HIV and hepatitis could be transmitted.
Reusing injection needles or syringes between clients	High risk	Injection needles must be disposed of in a puncture-resistant container (disposable) or processed for reuse to prevent transmission of blood-borne organisms from one client to another. To process correctly, use high-level disinfection or sterilization.
Breastfeeding from an HIV-positive mother	High risk	Although the risk is relatively high, if no other good source of nutrition is available, it is still recommended that an HIV-positive woman breastfeed.
Labor and delivery, risk to child when mother is HIV-positive	High risk	Risk can be significantly reduced with certain antiretroviral drug regimens and safe obstetric practices.
Sharing needles, syringes, drugs, or other drug paraphernalia	High risk	HIV and hepatitis can readily be transmitted from an infected person through sharing of injection needles and syringes.
Traditional circumcision	Unknown risk	If the razor blade or cutting instrument is reused and not properly sterilized, risk could be high.
Going to the dentist	Unknown risk	Depends on the dentist's infection prevention practices.
Receiving a blood transfusion	Unknown risk	In many countries, the blood supply is adequately screened for HIV.
Donating blood	Unknown risk	In the presence of correct infection prevention practices, there is no risk.

Stigma and discrimination⁷

Stigma is defined as an undesirable or discrediting attribute that a person or group possesses that results in the reduction of that person's or group's status in the eyes of society. Stigma can result from a physical characteristic, such as the visible symptoms of a disease, or from negative attitudes toward the behavior of a group, such as homosexuals or prostitutes.

Discrimination, which can be expressed as both negative attitudes or particular behavior or actions, is often described as a distinction that is made about a person that results in their being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong to a particular group.

"Stigma and discrimination associated with HIV and AIDS are the greatest barriers to preventing further infections, providing adequate care, support and treatment and alleviating [the] impact [of HIV and AIDS]" (UNAIDS, 2002).

Stigma and discrimination related to HIV and AIDS are almost as old as the epidemic itself. It is now widely recognized that stigma and discrimination are one of the three phases of the AIDS epidemic. The first phase is the silent spread of HIV throughout a society. This is followed by the second phase, the rising number of HIV-positive people whose health deteriorates and who are eventually diagnosed with AIDS. However, it is the third phase of the epidemic - the spread of stigma, discrimination, collective denial, and blame – that may be the most damaging of the three to a society's health. By making it difficult to openly discuss issues related to HIV and AIDS, stigma and discrimination act as obstacles to the establishment and implementation of effective prevention efforts.

It is important to understand that stigma and discrimination exist in a vicious cycle. Stigma encourages the development of discriminatory attitudes or prejudice. These attitudes are then often expressed in discriminatory behavior that draws attention to and reinforces the stigma. In this way stigma and discrimination reinforce and perpetuate each other.

Instances of discrimination related to HIV and AIDS have been recorded all over the world. People living with HIV (PLHIV) have been: the focus of gossip and rumors, segregated in schools, refused employment and housing, denied the right to marry, rejected by their communities and families, and even killed because of their HIV-positive status. Studies have found that PLHIV often internalize stigmatizing messages about themselves and suffer anguish and loss of hope about their future. Some PLHIV also suffer from severe depression that drives them to withdraw from social interactions and isolate themselves from the rest of society.

Sadly, many PLHIV have faced discrimination even when they go to seek assistance from those who are supposed to help them, the health care providers. Reported instances of discrimination related to HIV or AIDS within health care settings have been rising around the globe over the past few years. A list of examples of discrimination that PLHIV have faced in health care settings includes: having treatment delayed or denied, being provided inappropriate treatment,

⁷ Adapted from *Reducing Stigma and Discrimination Related to HIV and AIDS. Training for Health Care Workers*. EngenderHealth, 2004.

being discharge prematurely, being refused admission to a health care facility, being tested without consent, having their confidentiality breached, being called names, and being the subject of ridicule and degrading behavior.

Causes of stigma and discrimination related to HIV and AIDS

There are numerous factors that contribute to the creation of stigma and discrimination related to a particular characteristic, attribute, or disease within a society. When discussing stigma and discrimination related to HIV and AIDS within the context of health care settings, it is important to realize that there are two main groups of causes: societal factors and causal factors that are specific to health care settings.

One of the most important societal factors that contributes to the creation of stigma and discrimination related to HIV and AIDS is the general lack of knowledge about HIV transmission and AIDS. Studies have shown that people who are aware that casual transmission is impossible are less likely to be prejudiced against PLHIV than those people who are less knowledgeable about HIV transmission. Also, because AIDS is an incurable and degenerative disease, it is closely associated with death and the terminally ill. This association with death, along with poor levels of knowledge about HIV and AIDS, acts to increase stigma surrounding HIV and AIDS.

One of the reasons that stigma and discrimination related to HIV and AIDS are so difficult to overcome is that HIV and AIDS are linked to pre-existing prejudices. Long-standing stigma surrounding the first populations that were hit by the epidemic, such as homosexual men, prostitutes, and intravenous drug users, contributed to the general stigma associated with HIV and AIDS. HIV and AIDS became known as the "gay plague" or as a "woman's disease" throughout different parts of the world. Along with the association with these already stigmatized populations came the belief that people who became infected with HIV were receiving a just punishment for their previous "immoral" and "deviant" behavior. Sadly, because many PLHIV are members of groups that are already stigmatized and socially marginalized (such as the poor, homosexuals, and commercial sex workers), these people may experience multiple, compounding stigmas. The powerful effects of these compounding stigmas create new prejudices, and further entrench old prejudices within society that are extremely difficult to overcome.

In addition to the general societal factors that contribute to the creation of stigma and discrimination related to HIV and AIDS, there is another set of causes that is specific to health care settings. Perhaps the greatest of these factors is the fear that many health care workers (HCWs) have about getting infected while working. Although there is a slight risk of occupational exposure for HCWs, most of the HCWs' fears about casual occupational exposure are unjustified. Studies have shown that the unfounded fear of casual transmission that many HCWs have can be dispelled with accurate information and training. In addition, many HCWs hold the same prejudices that exist within the general society, and therefore may be upset at having to risk their health to treat people who became infected through what the HCWs believe to be "immoral," risky behavior. Along with all of the fear that HCWs may have about becoming infected is the concern that HCWs may have about becoming stigmatized as being HIV-positive or having AIDS as well.

HCWs who are faced with a lack of resources, whether it is drugs for treatment, testing kits, or a shortage of staff, may feel that treating PLHIV is not worth the time or effort. HCWs may believe that their time and energy is better spent assisting clients who are suffering from curable

conditions that are easier to manage than HIV or AIDS. Such attitudes, while perhaps not intended by the HCWs to be discriminatory, can prevent PLHIV from receiving the treatment and care that they require. In addition, PLHIV may face institutional discrimination when trying to access health care services. Some health care systems have discriminatory policies in place that restrict the ability of PLHIV to access treatment and health services, thereby denying them services (such as antiretroviral drug therapy) that could significantly improve and lengthen their lives.

Consequences of stigma and discrimination related to HIV and AIDS in health care settings

There are two types of consequences that can occur when stigma and discrimination related to HIV and AIDS exists within a health care setting: consequences for the targets of the stigma and for the whole society. It is important to realize that not all people who suffer from stigma and discrimination related to HIV and AIDS are HIV-positive or have AIDS. In fact, a person can be stigmatized and discriminated against when others simply presume that person is HIV-positive or has AIDS (perhaps because the person in question looks unhealthy or is known to participate in risky activities). As discussed above, when a client is assumed or known to be HIV-positive or living with AIDS, his or her health can suffer as he or she is denied access to necessary treatment and care. Furthermore, because PLHIV or people presumed to be living with HIV or AIDS know that they might encounter stigma and discrimination in a health care facility, some may elect not to attempt to access services, thereby decreasing the utilization of treatment services. In addition, because the stigma and discrimination associated with HIV and AIDS are so intense and undesirable, some people living with HIV or AIDS may go to extreme measures to avoid disclosing their status to others and subjecting themselves to stigma and discrimination. For example, PLHIV may avoid using condoms when having sex for fear that their partners may presume that they are infected. In this manner, stigma and discrimination actually contribute to the spread of the epidemic and decrease the efficacy of prevention efforts.

Besides creating obstacles for PLHIV or people presumed to be living with HIV or AIDS to access and utilize services and prevention methods, stigma and discrimination can also lead to severe psychological trauma for those targeted. Research has demonstrated that people who are stigmatized and subjected to discrimination because of their known or presumed HIV status often suffer from loss of self-worth, depression, and despair. Stigma and discrimination can also indirectly lead to the social isolation of people known or presumed to be living with HIV or AIDS. In fact, PLHIV are often isolated not only from other people, but oftentimes from the development process for HIV interventions as well. Stigma and discrimination cause PLHIV to be seen as some kind of problem, rather than as part of the solution to the epidemic. By not including PLHIV in the planning process for our HIV interventions, we miss out on prevention and epidemic management opportunities. Without including PLHIV in the planning process for HIV-related clinical services we miss out on the chance to get input from potential clients about how we can improve the services we offer and make them more attractive to PLHIV. By simply ensuring that PLHIV are included in the planning process for HIV-related services, we help to increase service utilization rates, which will eventually help to increase the efficacy of our prevention efforts as well.

It is important to realize that the consequences of stigma and discrimination related to HIV and AIDS extend beyond PLHIV and people who are presumed to be living with HIV or AIDS. In fact, there is another population affected by stigma and discrimination: people who are unsure about their HIV status - the potential targets of stigma and discrimination. The threat of being stigmatized and subjected to discrimination may be so strong that people who know they are at risk for HIV may elect not to get tested because they would rather not find out that they are HIV-

positive. Those people who purposefully avoid getting tested for fear of being stigmatized are then forced to live with the constant worry that they may be HIV-positive and in danger of developing AIDS. Furthermore, if a person is HIV-positive and decides not to get tested because they do not want to become stigmatized because of their HIV status, they may be unknowingly spreading HIV to others. This is yet another example of how stigma and discrimination perpetuate the growth of the epidemic.

It is evident that stigma and discrimination related to HIV and AIDS are harmful to PLHIV, people who are presumed to be living with HIV or AIDS, and to the entire society in general. In order to effectively combat the HIV and AIDS epidemic and to offer PLHIV the best clinical services possible, we must do everything we can to reduce the stigma and discrimination that exists today-particularly in health care settings. Only once stigma and discrimination are reduced within a society can prevention and treatment services reach their maximum potential levels of efficacy.

Reducing stigma and discrimination in the health care setting

In exploring attitudes and beliefs related to HIV and AIDS, we must look at how our attitudes and beliefs lead to stigmatizing certain individuals based on their HIV status or perceived status. Looking at our behaviors helps us to see the things we do that reinforce an unwelcoming environment for providing services to the community and individuals, including our colleagues. Once we have recognized these behaviors, we can find ways to change them. The following are some ways to protect clients' rights:

- Protect the client's right to privacy by ensuring that locations exist or are created where voices cannot be overheard during counseling and history-taking.
- Protect the client's right to confidentiality by keeping client records in a secured structure, immediately filing client records at the end of each session, and never discussing client management situations in areas of the facility where anyone can overhear the discussion.
- Avoid any labeling or signage in the service delivery area that would draw attention to clients with HIV or any other conditions that are stigmatized.
- Avoid separating clients with HIV from the general client population unless there is an indication, e.g., client is severely immunocompromised and prevention of infection is critical.
- Avoid using latex gloves for activities that pose no risk of exposure to blood or body fluids.
- Avoid nonverbal communication that portrays scorn, disgust, or disrespect (facial expressions, hand expressions when touching a client's utensils or clothing, etc.).
- Avoid any behavior that would communicate that the client is viewed as different.

Ensuring visual and auditory privacy: A checklist for providers⁸

Provider behavior

Visual privacy

- Honor patients' right to privacy.
- Place a "Do Not Disturb" sign on the door to discourage others from entering while counseling or examining a patient.
- Ask the patient's permission before bringing in another health professional for consultation or observation of the patient.
- Ask permission before bringing in the husband, mother-in-law, other family members, etc.
- Give contraceptive supplies or medications in a private area out of sight and earshot of others.
- If possible, use universal precautions (i.e., wearing gloves, safe disposal of sharps and sharps containers, etc.) with **all** patients to reduce calling attention to a particular patient.
- Never visit the patient at home without his/her permission.
- If making a home visit, ask the patient if he/she would like to talk to you away from the others so they cannot see you.

Auditory privacy

- Call out or announce the name of the patient to be seen, but never the type of service he/she is receiving.
- Never ask a patient in the presence of others what he/she is being seen for.
- If others are present, find a private place to ask a patient sensitive information.
- Speak in a soft voice so that others cannot hear you.
- Always close the door when talking to a patient.
- Discontinue interviews if an unauthorized person enters the room.
- Never discuss a patient's exam or test results out loud where others can hear.

⁸ *Ensuring Privacy and Confidentiality in Reproductive Health Services: A Training Module and Guide.* Washington, D.C.: PATH (2003).

- Never call out or otherwise reveal a patient's HIV status to coworkers. If HIV status must be revealed to a doctor or other health professional for medical reasons, do so only under complete auditory privacy.
- If making a home visit find a place to talk where others cannot hear the conversation.

Health center design

Services and space

- In integrated services, do not distinguish family planning or STI/HIV/AIDS services from other services so that the purpose of the patient's visit will not be obvious to others.
- Use symbols (colors, flowers, numbers, etc.) to indicate where different patients should go. Do not label rooms with the names of the distinct services.
- Inform the patient of the health center's policy on privacy and confidentiality via brochures or posters placed in the health center.
- If possible, create patient routes that produce one-way traffic to avoid jams and crowded areas where patients can be overheard.⁹
- Arrange an alternative site for partner/couple counseling if men express unwillingness to attend a family planning clinic.

Reception area

- Post a statement or poster where patients can readily see it to inform patients of their right to privacy and the health center's policy on protecting confidentiality.
- Use sign-in procedures that do not distinguish between types of services, such as one sign-in page for all services.
- Use numbers or other anonymous symbols to refer to patients in the filing system.
- Place materials on STIs, including HIV, together with materials about other health topics so that attention is not drawn toward a person looking at particular materials.

Counseling and/or examination area

- Create private space for taking health histories and providing counseling, such as a booth, a screened-off area, or a separate office to improve visual privacy.
- Designate a private place for the patient to be in after getting his/her test results, and allow him/her time to compose him or herself if the results evoke an emotional reaction.

⁹ Management Sciences for Health. "Making your building work." *Managing Quality & Clinical Services. The Manager online* (<http://erc.msh.org>).

- If a patient is referred for another service, ask the patient to complete an informed consent form that authorizes the health center to disclose the patient's health information to the referral center.
- Provide a door, curtain, or screen in the examination area to protect patients from being seen while they get dressed and undressed.

<p>Note: While a movable partition provides visual privacy, this is not generally adequate for auditory privacy.</p>

- Move the examination table out of view or use a curtain or screen between the door and the examination rooms. Be sure that a patient can move from the examination area to the dressing area without being seen by others.
- Arrange examination tables in the exam rooms to avoid exposing private parts if someone accidentally opens a door or walks in while a person is being examined. For example, place the exam table facing away from the door or window.
- Use frosted or thick glass or a curtain/screen to block windows in the examination/dressing area.

Policies and procedures

- If private spaces do not exist, advocate for private rooms for examining and counseling patients, especially for STIs, including HIV, and AIDS testing and counseling.
- Provide childcare apart from the counseling room for children over age three so that they do not overhear their parent's conversations.
- Post a statement regarding standards of privacy for all providers to see. Make staff aware of consequences of violating the patient's rights.
- Train all health center staff, outreach workers, and volunteers on the moral and legal issues surrounding privacy and confidentiality and how to ensure privacy and confidentiality at all levels of reproductive health service delivery.
- If test results must be sent to patients by mail, use blank envelopes that do not have the name of the testing center on them, since other people, such as post office workers or family members, may see the envelope before the patient does.
- Establish protocols for privacy and policies for breaches.

Ensuring confidentiality of patient information: A checklist for providers¹⁰

Provider behavior

- Look out for the patient's best interests, recognizing that some patients, particularly poor women and adolescents, have difficulty understanding their rights.
- Honor the patient's right to privacy and observe the provider's duty to protect information about the patient.
- Always assure patients of privacy and that the confidentiality of all information about his/her visit will be protected. Explain how the information will be used and that this information will not be disclosed to another person without the patient's permission.
- Never coerce a patient to give consent to release information.
- If a patient has been seen at a health center, take care not to inadvertently disclose that information to a parent or partner during the patient's subsequent visit.
- Call the patient into a private counseling room to discuss test results. Never mention test results or the availability of test results out loud.
- Obtain authorized consent from the patient before disclosing information to any other person, including husbands, parents, other family members, or to other organizations.
- Do not mention the reason to schedule a return visit or anything else related to the nature of the patient's visit in the presence of other patients.
- Keep the purpose of the patient's visit and any personal information about a patient or his/her test results confidential. Do not reveal this to others within or outside of the clinic.
- Do not gossip about a patient to coworkers, family members, or friends.
- For adolescents: life-threatening, emergency conditions may require parental notification. In non-life-threatening situations, providers must carefully weigh the potential harmful consequences for the adolescent before deciding to inform his/her parent(s). Follow international guidance or local laws on adolescents' right to privacy.
- Never visit the patient at home without his/her permission.

For STI/HIV/AIDS patients

Obtain a patient's permission before notifying his/her partner(s) if STI/HIV/AIDS results are positive. Do not notify the partner(s) without the patient's permission. Encourage the patient to inform his/her partner(s) and offer assistance.

Offer patients the opportunity to have couple's counseling but give the test results to each partner separately. Allow him/her to decide whether to share the results with his/her partner.

¹⁰ *Ensuring Privacy and Confidentiality in Reproductive Health Services: A Training Module and Guide*. Washington, D.C.: PATH (2003).

- If laws exist for mandatory partner notification or reporting of STIs, including HIV, test results, inform the patient what is done with the information collected about him/her before the test is given. Give the patient the opportunity to consent to proceed or to withdraw from being tested.

Health center design

- Place schedule books or computer screens or other places for appointments away from view of other patients.
- Keep personal medical records and information in a locked drawer or file cabinet, or provide a space where they can be locked up.
- Set up confidential record-keeping systems, such as using numbers instead of patient names.
- If a patient's record must have his/her name on it, organize the patient files by a number system, not an alphabetical system. This added layer of security makes it more difficult for an unauthorized person to find a file using the patient's name.
- For STI or HIV testing, assign a unique identification number that is attached to the test in the presence of the patient before the sample is submitted for testing. Then give the patient the number so that the patient's name and test results will be separate.
- If test results must be sent to the patient by mail, do not include the name of the testing center on the return address, since other people, such as post office workers or family members, may see the envelope before the patient does.

Policies and procedures

- Establish policies on the use and disclosure of a patient's personal health information.
- Develop clear and specific protocols for private and confidential services and for addressing breaches of confidentiality.
- Ensure that all providers and others who interact with patients understand these protocols and agree to uphold them.
- Set up a system for monitoring how confidential procedures are being followed.
- Deal decisively with breaches in confidentiality.
- Limit access to patients' files and records to only staff that needs to know this information in order to treat the patient.
- Institute consent forms so that only patients authorize the release of their own medical information.
- Ensure that consent procedures (e.g., obtaining informed consent for a procedure or informed authorization of release of information) are strictly adhered to.
- For referrals to other services, ensure that other health centers/organizations receiving a patient's information have policies in place that protect the confidentiality of information.
- Develop policies for treating adolescents and ensure that all personnel are aware of these policies.

Taking a sexual history¹¹

Before taking a sexual history, be aware of the following:

Maintain a neutral attitude.	Be aware of your own discomfort with the subject and recognize that your attitude will affect the client.
Remain aware of cultural factors.	The client's cultural background can affect willingness to discuss sexual activity.
Establish rapport.	Don't jump right into detailed questions about sexual activity. Get to know the client first and put him/her at ease with small talk or other, less potentially threatening topics.
Explain what you need to discuss and why.	Questions about sexual activity can seem intrusive and often provoke anxiety; briefly explaining the reason can motivate candor in the client who wants to receive the best possible care. "In order to make sure we consider all the possible reasons for your symptoms (or: your overall health) we also need to discuss sexual activity."
Use "we" statements as much as possible.	These are inclusive and indicate that the provider is willing to be a part of the process. "You" statements and questions are unavoidable when gathering information about specific activities; however, they can alienate when introducing the need to explore sexual history. It is less intimidating to say, "We need to discuss sexual activity," than to say, "I need to know about your sexual history."
Use appropriate vocabulary.	Use terms that the client understands and is comfortable with. Use polite or behavioral terms unless the client signals a preference for slang or indicates a lack of comprehension. "Check in" with the client to be sure you are being understood.
Use specific time frames.	Preface your questions about sexual activity with specific time frames: "During the past three months have you..." or, "When was the last time you..."
Use gender-neutral terms.	When asking about or discussing sexual activity, use the term "partner" even if the client has already made a reference to the gender of one or more sexual partners. This leaves the door open for the client to comfortably disclose activity that you might not have suspected. Early in the course of a sexual history, you might ask: "During the past (time frame) have your sexual partners been men, women, or both?"

¹¹ HIV counseling for Health Care Professional, Washington State Department of Health, 2000.

Verbal and nonverbal clues can indicate the provider's discomfort with the issue(s). The provider's discomfort can compromise the client's candor.

<i>Discomfort</i>	<i>Comfort</i>
Verbal	
Beginning a statement with, "I'm sorry, but I have to ask you..."	Beginning a statement with, "We need to discuss..."
Self-fulfilling prophecy: "I know this is uncomfortable for you, but..."	Acknowledge <i>possible</i> discomfort and explain the reason for asking for the information: "Some people are understandably uncomfortable discussing these things, but it is necessary in order to provide you with the best possible care."
Cracking or wavering voice; speaking too softly as if discussing something "dirty."	Make statements/ask questions at an even pace, in a "matter-of-fact" tone, as if discussing a neutral topic.
Nonverbal	
Darting eye movements; brief eye contact; intent, unbroken stare; or no eye contact at all.	Relaxed focus on the entire face, not just the eyes; occasional breaks in eye contact.
Stiff posture; arms held in tightly.	Shoulders down; arms/elbows loosely at sides.
Fidgeting hands; picking at fingernails; tapping pencil.	Hands on chart or held still in the lap or on the desk; occasional, appropriate gestures.

Pre-test HIV counseling guide^{12, 13}

I. Introduction

1. Introduce yourself, welcome the patient, establish rapport, and put the patient at ease.
2. Identify your role and explain what a counselor does.
3. Explain the purpose of the session.
4. Inform the patient about the following:
 - a. Confidentiality provisions in your setting:
 - All information discussed will kept confidential.
 - Criminal responsibility of the medical provider for disclosure of patient's private information.
 - Anonymous testing and counseling options are available.
 - Confidential and anonymous notification about test result (the patient personally).
 - b. HIV testing is free of charge.
4. Explain that VCT procedure includes pre-test counseling, HIV test, and post-test counseling.
5. Ensure that the patient understood you and answer any questions that he or she may have.

II. Help the patient to assess the risk

1. Determine why the patient is interested in taking the test.
2. Determine if the patient has been tested before. History of HIV antibody testing and results.
3. Determine patient's assessment of personal risk and discuss the main ways of HIV transmission. Listen for and address, as appropriate, information such as the following:
 - History of STDs and having sex with persons who have STDs, especially genital lesions.
 - Sharing needles or having sex with persons who share needles.
 - Blood transfusion.
 - Permanent sex partner and what does it mean.
 - Sexual activities including vaginal, anal, and oral sex, both receptive and insertive activities.
 - Sex with a person known to be HIV-positive or IV drug-user.
 - Consumption of alcohol, smoking pot, or injecting drugs before sex.
 - Sex in exchange for drugs, money, or other inducements.
 - Condom use.

Recommended questions:

What leads you to think that you may be infected with HIV?

In what ways do you think you may have been exposed to HIV?

(If "Yes" for the following questions, probe patient's response.)

Have you had sexual contacts with multiple partners?

Have you had sexual contacts (vaginal, anal or oral) with any of your partners without a condom?

¹² HIV Counseling for Health Care Professionals, Washington State Department of Health, 2000.

¹³ National Protocol on Voluntary Counseling and Testing on HIV, MOH of Ukraine, 2005.

- Birth control – pregnancy prevention methods.
4. Assess patient's partner risk (sexual contact with somebody else; other risk behavior).
 5. Summarize main patient's risk factors and make sure he or she understands how HIV is transmitted.
 6. Answer patient's questions.

III. Identify and negotiate safer behaviors

1. Review with the patient safe behavior models that are relevant to his or her identified risk:
 - Abstain from sex and injecting nonprescription drugs.
 - Practice mutual monogamy (with a seronegative partner).
 - Use condoms/barriers with water-based lubricant (in every possible situation of HIV/STD transmission).
 - Limit number of sex partners.
 - Limit the use of alcohol or other drugs, as they can impair judgment and lead to unsafe sex and sharing of drug-injection equipment.
 - Consider screening for sexually transmitted diseases (including hepatitis B, when appropriate).
 - Obtain family planning assistance (when appropriate).
 - Enroll in a drug treatment program (when appropriate).
 - Do not share drug-injection equipment (if using injectable drugs).
 - Bleach drug-injection equipment (if sharing drug-injection equipment).
 - Observe universal precautions for blood-borne pathogens.
2. Negotiate a realistic plan to reduce risks.
3. Determine what additional help the patient needs to follow this plan.

IV. Help the patient make the decision

1. Assess and reinforce patient's coping skills. Discuss patient's plan to cope with the waiting period. If the patient anticipates anxiety and distress, then determine how the client has handled past stressful situations and who is available for support.
2. Explain benefits of testing, including medical benefits of early diagnosis of HIV and of receiving early intervention services.
3. Explain about the three-month "window" period.
4. Inform the patient that according to Ukraine law, a person is criminally responsible for consciously infecting another person with HIV.
5. Discuss patient's fears and concerns about HIV testing.

Do you take intravenous drugs and if so, do you ever share needles with others?

What have you been doing to protect yourself from HIV and other STDs?

How has that been working for you?

What else do you feel you need to do in order to protect yourself?

What difficulties do you think you might encounter with this plan?

What can you do to deal with those challenges?

6. Determine if the patient wants to be tested.
7. Explain procedures for testing.
8. Make sure that the patient understands what test results mean:
 - Negative: patient was not HIV-infected 3 months ago.
 - Positive: patient is HIV-infected and will be made aware of the social and health services available. Besides, he or she will be provided post-testing counseling, which will help make the action plan for the future.
 - Indeterminate: result was not clear, so it did not allow determining the status; to receive the ultimate result, the test has to be repeated.
9. Get written informed consent.
10. Explain procedure for obtaining results and post-test counseling.

V. Conclusion

1. Reinforce returning for test results.
2. Set a date when the patient can come and pick up the results.
3. Provide handouts reinforcing risk-reduction messages.
4. Address final questions or concerns.

It is desirable that the same provider that conducted the pre-test counseling informs the patient about the test results and provides the post-test counseling. That would allow the patient feel more secure and would increase his or her trust in adherence to confidentiality. If that, by any reason, is impossible, you should explain to the patient the reasons for your absence at the moment when he or she receives the results and ask his or her permission to pass the information to another provider.

Post-test HIV counseling guide (negative result)^{12, 13}

I. Introduction

1. Greet the patient.
2. Briefly introduce yourself and establish rapport.
3. Remind the patient about confidentiality.
4. Assess and accommodate the patient's emotional state.
(*This part should not be lengthy.*)

Sample script

II. Inform the patient about his or her test results

1. Give test results. Pause.
2. Wait for the initial reaction from the patient and his or her questions.
3. Calmly discuss meaning of the test result:
 - Client was not infected as of three months ago.
 - Limitations of test (i.e., time lag between infection and development of antibodies).
 - Option of retesting, if the patient has recent risk or exposure, or experiences new risk.
(*Let the patient speak out, ask him or her open-ended questions, and help him or her express his or her fears and anxieties. Before going over to the next stage, make sure the patient grasps the information that you have provided.*)
4. Discuss whether the client wants to inform his or her partner about the test result and use this opportunity to check the partner's HIV status.

The test on your blood came back negative. This means you can be very confident that you were free of HIV infection as of three months ago. However, a more recent infection may not show up on this test.

III. Identify and negotiate safer behaviors

1. Review patient's knowledge of the risk-reduction messages from the pre-test counseling session:
 - Abstain from sex and injecting nonprescription drugs.
 - Practice mutual monogamy (with a seronegative partner).
 - Use condoms/barriers with water-based lubricant in every possible situation of HIV/STD transmission.
 - Limit number of sex partners.
 - Do not share drug-injection equipment (if using injectable drugs).
 - Bleach drug-injection equipment (if sharing drug-injection equipment).
 - Observe universal precautions for blood-borne pathogens.
2. Discuss and develop a plan to prevent the patient from being infected in the future.

How do you plan to stay free of HIV infection and other sexually transmitted infections?

IV. Assess the patient's coping skills and discuss follow-up plan

1. Identify the type(s) of support that the patient requires.
2. If necessary, schedule repeat test and counseling.
3. Provide appropriate referrals for the patients who are in need of any of the following services:
 - Screening for sexually transmitted infections (including hepatitis B, when appropriate).
 - Family planning assistance.
 - Drug treatment.
4. Provide the patient with educational materials (if available) on HIV, STDs, or on correct use of condoms; also inform him or her about available social and health support services.

V. Conclusion

1. Summarize the main issues that were discussed and decisions made.
2. Address final questions or concerns

What difficulties do you anticipate with your plan?

What could help you deal with those challenges?

What other questions or concerns do you have about your test result or about avoiding HIV infection?

Post-test HIV counseling guide (positive result)^{12, 13}

I. Introduction

1. Greet the patient.
2. Briefly introduce yourself and establish rapport.
3. Remind the patient that his or her visit and medical information are confidential.
4. Assess and accommodate the patient's emotional state.
(*This part should not be lengthy.*)

II. Inform about the testing results

1. Give test results. Pause briefly to give the patient time to absorb information.
2. Wait for the initial reaction from the patient and his or her questions.
3. Calmly discuss meaning of the test result:
 - Patient is infected.
 - Patient can infect others.
 - Prognosis and progression of disease vary from one person to another, and will depend on the patient's particular case (from long periods of good health to serious immune system damage and death).
 - Infection does not mean disease. Explain the difference between being infected with HIV and having AIDS.
4. Assess patient's emotional status.
5. Discuss what positive HIV status means for the patient and possible consequences for personal life and relations with family and friends.
6. Discuss with the patient possible plans to provide him or her with further support, tell about existing groups for social and psychological support with respective referral and contact information, or arrange for him or her to meet with volunteers.

III. Discuss partner notification

1. Discuss the benefits of locating and counseling all past and present sex and needle-sharing partners.
2. Develop a plan to notify all partners through patient or provider referral.
3. Discuss the option for the patient's partner(s) to get tested for HIV.
4. Assess patient's plans for the immediate future (after leaving the clinic, later today, this week).

IV. Discuss medical follow-up

1. Discuss medical advancements and benefits of early medical intervention.

Sample script:

The test of your blood came back positive. This means that you do have HIV infection. This also means that you are able to pass the infection to others through unprotected sex or blood-to-blood contact.

How are you feeling right now? Who can you talk to about this result?

It can be very difficult to discuss this with your sex (needle) partner(s) – and it is very important for them to know. How do you plan to talk about this with your partner(s)?

2. Discuss available treatment options, routine medical interventions (TB treatment options, social and psychological support, further steps to treat HIV infection, etc.).
3. Recommend that the patient visit a health care provider as soon as possible. Recommended follow-up procedures include:
 - Screening for hepatitis B.
 - Screening for STIs.
 - Consultation at family planning center (if necessary).
 - Monitoring immune system and general health.
4. Discuss possibility to have sexual relations and children.
5. Assist the client in developing a plan to maximize medical and emotional support.

V. Identify and negotiate safer behavior model

1. Discuss patient's plan to protect *self* and prevent transmission to protect *others*.
2. Discuss patient's obligation to inform prospective partners about his or her positive HIV status in advance of any sex or needle-sharing and his or her legal responsibility according to the Ukraine legislature.
3. Review patient's knowledge of the following risk-reduction options for his or her self and partners:
 - Abstain from sex or injecting nonprescription drugs.
 - Practice mutual monogamy with informed partner – avoid transmission to partner or reinfection of self.
 - Use condoms/barriers with water-based lubricant in every possible situation of HIV/STI transmission.
 - Limit number of sex partners.
 - Limit the use of alcohol and other drugs, as they can impair judgment and lead to unsafe sex and sharing of drug-injection equipment.
 - Enroll in a drug treatment program.
 - Do not share drug-injection equipment; use syringe exchange.
 - Bleach drug-injection equipment.
 - Obtain family planning assistance.
 - Do not share personal items that may contain blood, semen, or vaginal fluids (e.g., razors, toothbrushes, sex toys).
4. Provide information on perinatal transmission.
5. Tell the patient not to donate organs, sperm, blood, or blood products.
6. Get patient's written confirmation that he or she received all information listed above.
7. Provide informational materials if available.

It's important to avoid passing this infection on to others and to avoid re-exposing yourself to it. What choices are going to work for you to protect yourself and others?

VII. Conclusion

1. Summarize the main steps of the follow-up plan.
2. Provide necessary referrals.
3. Address any further issues or concerns.

Post-test HIV counseling guide (indeterminate result)^{12, 13}

I. Introduction

1. Greet the patient.
2. Briefly introduce yourself and establish rapport.
3. Remind the patient that his or her visit and personal information are confidential.
4. Assess and accommodate the patient's emotional state. (*This part should not be lengthy.*)

II. Inform the patient about his or her test results

1. Give test results. Pause for a moment.
2. Wait for the initial reaction from the patient and his or her questions.
3. Discuss the meaning of the test result:
 - The test result was not clear and did not allow the lab to determine the status; to receive an accurate result, the test has to be repeated.
4. Make sure that the patient understands the importance of a repeat test.

Your test result was not clear and did not allow the lab to definitely tell whether there are HIV antibodies in your blood or not.

Is there a person with whom you can discuss this issue?

III. Develop plan of behavior for the waiting period before obtaining retest results

1. Discuss the importance of maintaining safe behavior while waiting for the test result in order to protect the patient and his or her partner.
2. Discuss patient's plans for the near future – his or her intentions and actions.

IV. Assess the patient's coping skills and discuss follow-up plan

1. Evaluate the patient's feelings during the waiting period.
2. Identify the type(s) of support that the patient requires.
3. Schedule repeat test and counseling.
4. Provide the patient with educational materials (if available).

V. Conclusion

1. Summarize the main issues that were discussed and decisions made.
2. Address final questions or concerns.

Ukrainian laws on HIV and AIDS*

The right of health protection is an inalienable part of human rights as a whole. Article 49 of the Constitution of Ukraine, as well as Article 6 of the Law of Ukraine “Principles of Legislation of Ukraine on Health Protection” read: “Everyone has the right to health protection.” With regards to voluntary counseling and testing for HIV, the following legal acts are indirectly applicable to this issue in Ukraine:

1. The Constitution of Ukraine (Article 49).
2. The Law of Ukraine “Principles of Legislation of Ukraine on Health Protection” No. 2801-XII of 19.11.1992 (Articles 6, 39, 40, 43, and 53).
3. The Law of Ukraine “On Prevention of the Acquired Immune Deficiency Syndrome (AIDS) and Social Protection of the Population” No. 1972-XII of 12.12.1991 (as amended in 1998). This law, in accordance with international guidelines and WHO recommendations, defines legal regulation of activities aimed at preventing HIV spread in Ukraine and appropriate measures of social protection of PLHIV:
 - a. Chapter I – General provisions defining state guarantees in the AIDS response domain, Article 4.
 - b. Chapter II – Conditions for and the procedure of medical examination for detecting HIV infection. Registering PLHA, providing them with medical and nursing care, Articles 7, 8, 9, 11, and 12.
 - c. Chapter III – Implications of HIV detection and responsibilities of HIV-positive persons, Articles 14, 15, and 16.
 - d. Chapter IV – Social protection of persons infected with HIV, patients with AIDS and their families, Articles 17, 18, 19, 20, 21, 22, 23, and 24.
 - e. Chapter V – Social protection of health professionals and other persons whose professional duties raise the risk of HIV infection, Articles 25, 26, 27, 28, 29, and 30.
 - f. Chapter VI – Responsibility for violation of legislation in the HIV/AIDS response domain, Articles 31, 32, and 33.
 - g. VI – “Final provisions,” Article 34.
4. The Law of Ukraine “On Information” No. 2658-XII of 02.10.1992 (as amended by No. 1703-IV of 11.05.2004), Article 37 (Documents and Information that are not available for access by request).
5. The Criminal Code of Ukraine No. 2341-III of 5.04.2001, Articles 130, 131, and 132.
6. Resolution of the Cabinet of Ministers of Ukraine “Issues of prevention and population protection from HIV infection and AIDS” No. 2026 of 18.12.1998.
 - a. Procedure of medical examination for detecting HIV infection, registering PLHA, and providing them with medical and nursing care, Items 2, 3, 4, 5, 7, and 13.
 - b. List and standards of use of individual means of protection for employees of health facilities that carry out HIV diagnostics, provide care to PLHA, and have contact with blood and other biological materials of HIV-positive persons, Items 1 – 6.

* Trainers should refer to the national legislation of the country where the training is being done.

- c. Procedure for accreditation of special HIV/AIDS diagnostic laboratories, Items 1 – 27.
7. Resolution of the Cabinet of Ministers of Ukraine “On Approval of the Strategic Concept for Action of the Government Aimed at Preventing HIV/AIDS Spread for the Period up to 2011 and the National Programme for Ensuring HIV Prevention, Care and Treatment of PLHA for 2004 – 2008” No. 264 of 04.03.2004.
 - a. Chapter – Programme implementation activities, Items 9, 14, 18, and 21.
8. Order of the Ministry of Health of Ukraine “On Approval of the Instruction for Organizing HIV Diagnostic Work” No. 71 of 22.02.2002.
9. Order of the Ministry of Health of Ukraine “On Approval of the Guidelines for Using Rapid Tests for Screening Blood for Antibodies to HIV, the Registration Form No. 498/o and the Instructions for Filling It In” No. 255 of 09.06.2003.
10. Order of the Ministry of Health of Ukraine “An Improving Organization of Medical Care Provision to People with HIV/AIDS” No. 120 of 25.05.2000.
11. Joint Order of the State Penitentiary Department and the Ministry of Health of Ukraine “On Approval of Regulatory Legal Acts Pertinent to Medical and Sanitary Coverage of Persons Detained at Detention Facilities and Correctional Labor Facilities of the State Penitentiary Department” No. 3/6 of 18.01.2000.

The listed regulatory legal acts of Ukraine pertinent to VCT for HIV can be tentatively classified into the following groups:

1. Rights of citizens.
2. Rights of health professionals.
3. Rights of PLHA.
4. Responsibilities of PLHA.
5. Responsibilities of health professionals.
6. Methods of preventing health professionals from contracting HIV during execution of their professional duties.

The Constitution of Ukraine

Article 49. Everyone has the right to health protection, medical care and medical insurance. Health protection is ensured through state funding of the relevant socio-economic, medical and sanitary, health improvement, and prophylactic programs. The State creates conditions for effective medical service accessible to all citizens. State and communal health protection institutions provide medical care free of charge; the existing network of such institutions shall not be reduced. The State promotes the development of medical institutions of all forms of ownership. (For official interpretation of the provision of Part 3 of Article 49, see Decision of the Constitutional Court No. 10-rp/2002 [v010p710-02 of 29.05.2002].) The State provides for the development of physical culture and sports, and ensures a safe epidemiological environment.

THE LAW OF UKRAINE

Principles of legislation of Ukraine on health protection

Article 6. The right to health protection.

Every citizen of Ukraine has the right to health protection, which includes:

- a) Standard of living, including food, clothing, accommodation, medical care, and social services necessary for human health maintenance;
- b) Environment safe for life and health;
- c) Safe epidemiological environment of the territory and location of residence;
- d) Safe and healthy conditions for working, studying, everyday life, and recreation;
- e) Qualified medical care, including free choice of a doctor and of a health facility;
- f) Timely provision of valid information on his/her individual health status as well as on the public health situation, including existing and potential risk factors and their scope;
- g) Participation in discussions over proposed legal acts and the ability to make proposals regarding state health policy formulation;
- h) Participation in public health management and public expertise on these issues according to the procedure stipulated by law;
- i) Opportunity to form community-based organizations with the purpose of contributing to health protection;
- j) Legal protection from any illegal forms of discrimination related to health status;
- k) Reparations for damages to health;
- l) Appeals against illegal decisions and actions of health professionals, health facilities, and health authorities;
- m) Opportunity for carrying out a medical peer expert review in case of citizen's disagreement with findings of state expert review, or application of forced treatment measures to a citizen, as well as in other cases when actions of health professionals can violate generally recognized human and citizens' rights.

The legislation of Ukraine can also define other rights of citizens in the health protection domain. Citizens of Ukraine who are staying abroad are ensured the right to health protection in formats and volumes stipulated by international treaties that Ukraine participates in.

Chapter V

Curative and preventive care

Article 39. Responsibility concerning provision of medical information.

The physician is obliged to explain to the patient his/her health status, the purpose of proposed examinations and treatment measures, as well as the prognosis for potential development of the disease – including potential risks for life and health – in an accessible manner. The patient has the right to be made familiar with his/her case history and other documents that may be used during further treatment.

In special cases, when complete information can damage a patient's health, the physician can restrict it. In these cases, the physician informs the patient's family members or legal representatives, taking into consideration the patient's personal interests. The physician acts the same way as when the patient is unconscious.

Article 40. Medical confidentiality.

Health professionals and other persons who—in the course of executing their professional or work duties—learn about a citizen's illness, medical examination and its results, and intimate and family details of life have no right to disclose this data, with the exception of cases stipulated by legal acts. Should information that is of medical confidentiality be used in academic processes or in research work—including cases of the latter being published in specialized literature—the patient's anonymity must be ensured.

Article 43. Consent for medical intervention.

The consent of the patient informed in accordance with Article 39 of these Principles is necessary for applying diagnostic, preventative, and treatment methods. As for the patient who is a minor under 15 years of age and for the patient acknowledged as legally incompetent, medical intervention is carried out by consent of their legal representatives. (Part I of the Article 43 in the revision of the Law No. 1489-III [1489-14 of 22.02.2000].) In cases of emergency when a real threat to the patient's life is present, no consent for medical intervention is needed from the patient or his/her legal representatives.

If the lack of consent to treat may have serious negative implications for the patient, the physician is obliged to explain this. If the patient refuses to undergo treatment even after this notification, the physician has the right to obtain written confirmation from him/her; should that be deemed impossible, the physician has the right to have the patient's refusal verified with a suitable statement in the presence of witnesses. If a refusal is given by the patient's legal representative and it can have serious negative implications for the patient, the physician shall inform the guardian parties regarding the risk.

Article 53. Special measures of prevention and treatment of socially dangerous diseases.

With the aim of protecting population health, health authorities and health facilities are obliged to carry out special preventative and treatment activities targeting socially dangerous diseases, such as tuberculosis, mental diseases, sexually transmitted diseases, HIV/AIDS, leprosy, chronic alcoholism and drug dependence, as well as quarantine diseases. The procedure for hospitalizing and treating such patients, including that for forced treatment, is defined by legal acts of Ukraine.

THE LAW OF UKRAINE

On prevention of the acquired immune deficiency syndrome (AIDS) and social protection of the population

Chapter I
General provisions**Article 4.** The State guarantees:

- Ongoing epidemiological monitoring of HIV infection spread in the territory of Ukraine;
- Accessibility, quality, and efficacy of medical examination with the purpose of detecting HIV infection (hereinafter referred to as "medical examination"), on an anonymous basis, with provision of pre- and post-test counselling, as well as safety of such medical examination both for the person examined and for personnel carrying it out;
- Regular and full-scale provision of information to the population, by means of mass media, on causes of HIV infection, routes of transmission, and measures and means of prevention necessary for preventing infection and its spread;
- Inclusion of special topics related to HIV/AIDS prevention into curricula of secondary, technical, and higher educational settings;
- Ensuring the population's access to preventative means that prevent sexual transmission and spread of HIV infection;
- Prevention of HIV infection spread among persons who inject narcotic drugs—in particular, by creating favorable conditions for exchanging used needles and syringes for sterile ones;

- Compulsory screening for the purpose of detecting HIV in the blood or blood products obtained from blood donors and donors of other biological fluids, cells, tissues, and human organs used in medical practice and scientific research;
- Promotion of activities directed at forming safer sexual behavior standards among the population and at building awareness about the high HIV risk closely associated with injecting drug use;
- Social protection of HIV-positive people, patients with AIDS, their families and health professionals working in the field of HIV/AIDS response, as well as provision of all kinds of medical care in the manner prescribed by this Law and other regulatory legal acts to PLHA;
- Safety of diagnostic and treatment processes for patients and medical staff at public health facilities, state-run safety surveillance over these processes at health facilities of all forms of ownership, as well as over implementation of activities aimed at preventing HIV infection spread in private medical practice and during provision of cosmetic, barber, and other services related to the breaking of intact skin or mucous membranes;
- Facilitation of charitable activity aimed at the prevention of HIV infection spread, HIV/AIDS response and social protection of the population.

Chapter II

Conditions for and procedure of medical examinations with the purpose of detecting HIV infection. Registration of PLHA, provision of medical care to them and medical observation over them

Article 7. Citizens of Ukraine, citizens of other states, and stateless persons permanently residing or temporarily legally staying in the territory of Ukraine shall have the right to:

- Undergo a medical examination with the purpose of detecting infection by HIV; and
- Obtain an official statement on results of such medical examination and qualified recommendations regarding prevention of HIV spread.

The right to carry out medical examinations and to issue official statements on its results shall be granted only to public and communal health facilities possessing appropriately equipped specialized laboratories that are accredited in the manner prescribed by the Cabinet of Ministers of Ukraine.

Medical examination is carried out on a voluntary basis. The medical examination of minors under 18 years of age and of persons acknowledged as legally incompetent can be carried out by request or by consent of their legal representatives, who have the right to be present during such examinations. The medical examination of citizens of Ukraine, citizens of other states, and stateless persons permanently residing in the territory of Ukraine or having refugee status is carried out on no-fee basis. Medical examination payment arrangements for other categories of foreign citizens are prescribed by the legislation and appropriate international treaties of Ukraine.

The person having undergone a medical examination has the right to a repeated examination at any time at the same health facility or at any duly accredited health facility of their choice.

Article 8. At wish of the person having been referred to a health facility for medical examination, the examination can be carried out on an anonymous basis. Data on the findings of the medical examination – the presence or absence of HIV infection in a person having undergone the medical examination – are private and medically confidential. The right to transferring such data is granted only to the person whom the data concerns and, in cases stipulated for by the laws of

Ukraine, also to legal representatives of the person, health facilities, prosecution and investigating authorities, inquiry bodies, and divisions of the court.

Article 9. The person in whom HIV infection has been detected is informed of this fact by a health professional from the health facility at which the medical examination was carried out, taking into account the statutory requirements of this law regarding the confidential nature of mentioned information. At the same time, the HIV-positive person is informed of the necessity of taking preventative measures aimed at preventing HIV infection spread, guarantees related to observance of rights and freedoms enjoyed by HIV-positive people, as well as criminal responsibility for knowingly putting other persons at risk of being infected with human immunodeficiency virus, or knowingly infecting them.

Should HIV infection be detected in minors under 18 years of age, as well as in persons acknowledged as legally incompetent, a health professional from the health facility at which the medical examination was carried out shall inform the parents or other legal representatives of mentioned persons.

The procedure of informing examined persons on the medical examination results and issuance of appropriate official statements is established by the Ministry of Health of Ukraine.

Article 10. Blood (or blood products) obtained from donors of blood (or its products) and donors of other biological fluids, cells, tissues, and human organs are subject to compulsory screening for HIV infection. Transfusion of blood (or its products) as well as use of other biological fluids, cells, and tissues for medical purposes is allowed only after compulsory screening of donor blood for HIV infection. In order to prevent HIV infection spread through donor blood and its transfusion, blood transfusion shall be used only in cases when such medical intervention is the only life-saving means available. (Article 10 amended with a part in accordance with the Law No. 2776-III [2776-14 of 15.11.2001].)

In cases where an immediate threat to human life is present and the only life-saving means is blood transfusion but no duly screened donor blood is available, transfusion of blood screened by HIV with rapid tests is allowed by patient's consent or by consent of the patient's legal representative. Should it be impossible to obtain patient's informed consent or consent of patient's legal representative, the decision on transfusion of such blood is determined by council of physicians; should convocation of a council be impossible, the decision is made by the physician providing medical care. The act of transfusion of blood screened for HIV with rapid tests as well as the patient's consent or consent of patient's legal representative for such medical intervention shall be compulsorily verified in writing in the patient's medical record, while a sample of this blood shall be urgently sent for appropriate laboratory testing. (Part of Article 10 in the edition of the Law No. 2776-III [2776-14] of 15.11.2001.)

Article 11. Diplomatic missions and consular institutions of Ukraine issue an entry visa to Ukraine to citizens of other states and stateless persons arriving to Ukraine for a term of over three months on condition that they submit a document certifying their HIV-free status, unless prescribed otherwise by international treaties of Ukraine. Requirements to the mentioned document are established by the Cabinet of Ministers of Ukraine.

Article 12. Registration of PLHA who are Ukrainian citizens, citizens of other states, or stateless persons permanently residing or temporarily validly staying in the territory of Ukraine – as well as medical observation over mentioned persons – is ensured by appropriate public and communal health facilities as defined by the Ministry of Health of Ukraine.

Registration of PLHA as well as medical observation of them shall be carried out with observance of principles of confidentiality and respect to personal human rights and freedoms as defined by laws and international treaties of Ukraine.

Provision of medical care to PLHA who are Ukrainian citizens, citizens of other states, or stateless persons is carried out on general basis in the manner prescribed by the legislation and appropriate international treaties of Ukraine.

Chapter III

Implications of HIV infection detection and responsibilities of HIV-positive people

Article 14. At the occasion of being informed by the health facility about HIV infection detected in them, and having received warning regarding the need to take preventative measures to prevent spread of HIV infection and regarding criminal responsibility for knowingly putting other person(s) at risk of being infected or knowingly infecting them, HIV-positive people are obliged to acknowledge receipt in writing of the indicated information and warning.

Article 15. PLHA are obliged to:

- Take measures to prevent the spread of HIV infection as suggested by health facilities in accordance with Part I of Article 9 of this law;
- Inform persons whom they have had sexual contacts with before being diagnosed with HIV infection about the possibility of infection;
- Permanently refrain from donating blood, its products, other biological fluids, cells, and tissues for use in medical practice.

Article 16. Foreign citizens or stateless persons who, being HIV-positive or having AIDS, do not take preventative measures suggested by health facilities to prevent spread of HIV infection and who put other persons' health at risk by their behavior can be deported from Ukraine in the manner prescribed by the Law of Ukraine "On legal status of foreigners" (3929-12).

Chapter IV

Social protection of HIV-positive people, patients with AIDS and their families

Article 17. Citizens of Ukraine who are HIV-positive or have AIDS enjoy all rights and freedoms stipulated for by the Constitution and laws of Ukraine, as well as by other regulatory legal acts of Ukraine.

In addition to general rights and freedoms, they also have the right to:

- Compensation for damages related to restriction of their rights due to disclosure of information about their HIV-positive status;
- No-fee provision of medications necessary for treatment of any illness present in them, of individual means of prevention, and of social support;
- No-fee travel to the treatment site and back at the expense of the health facility that referred them for treatment;
- Separate residence rooms.

Participation of PLHA in clinical trials of pharmaceuticals and medical methodologies, scientific research of academic process, photographing, video- or cinematographic recording is permissible only by their consent.

Use of blood and other biological materials of HIV-positive people or patients with AIDS for scientific research is permissible only by their consent and implies receipt of compensation in the manner prescribed for by the Cabinet of Ministers of Ukraine.

Article 18. It is prohibited to withhold admission to health facilities or health care provision, to violate other rights of persons on the basis of them being HIV-positive or having AIDS, or to violate the rights of their family and close friends on this basis.

Article 19. Misconduct of officials that violates the rights of PLHA, as well as the rights of their family and close friends, can be challenged in court.

Article 20. Persons infected with HIV through medical manipulations have the right to being judicially compensated for damage to their health at the expense of the guilty party.

Article 21. Parents of HIV-positive children or those with AIDS as well as persons who are taking the place of parents have the right to:

- Joint hospital stays with children under 14 years of age, temporary exemption from work and receipt of benefits for temporary disablement due to taking care of an ill child;
- Retain an uninterrupted length of service, being parents dismissed from work due to taking care of an ill child under 16 years of age, for charging temporary disablement benefit on condition that they are re-employed before the child reaches school age.

Article 22. Mothers of HIV-positive children or those with AIDS under 16 years of age have the right to receive annual leave in summer or at any other period at their convenience. In the case that the mother is absent and the child is being brought up by the father or another person, this right is granted to indicated persons.

Article 23. Children under 16 years of age who are HIV-positive or have AIDS are assigned a monthly public welfare in amount established by the Cabinet of Ministers of Ukraine.

Article 24. HIV-positive citizens of other states and stateless persons permanently residing or temporarily legally staying in the territory of Ukraine, as well as those with AIDS, have the right to social protection in the manner and extent defined by the legislation of Ukraine and appropriate international treaties of Ukraine.

Chapter V

Social protection of health workers and other persons whose professional duties raise the risk of HIV infection

Article 25. Infection of health and pharmaceutical workers with HIV during execution of their professional duties pertains to occupational diseases.

Article 26. Employees providing medical care to the population, engaged in laboratory and scientific research on HIV-infection issues, and engaged in production of biological materials for HIV/AIDS diagnostics, treatment, and prevention are subject to compulsory insurance at the expense of the owner (or the owner-authorized body) of the health facility in case of becoming

infected with HIV while executing professional duties, as well as in case of becoming disabled or dying of HIV-associated illnesses. Categories of employees subject to compulsory insurance and insurance procedure are established by the Cabinet of Ministers of Ukraine.

Article 27. Health professionals who have contracted HIV or developed AIDS due to the execution of professional duties have the right to annual no-fee vouchers for sanatorium and spa treatment at specialized health improvement institutions of ministries and other central executive bodies whose sphere of competence the respective medical services belong to, as well as the right to annual leave with a total duration of 56 calendar days which may be used in the summer or at any other time at their convenience.

Article 28. Health professionals who have contracted HIV or developed AIDS due to the execution of professional duties have the right to top-priority improvement of housing conditions in the manner prescribed by the legislation of Ukraine.

Article 29. Employees providing medical care to population, engaged in laboratory and scientific research on HIV implying use of infectious material, and engaged in the production of biological materials for HIV/AIDS diagnostics, treatment, and prevention are eligible for additional wages, right to old age pension on a preferential basis, and annual additional leave in the manner prescribed by the legislation of Ukraine.

Article 30. The owner (or the owner-authorized body) of the health facility whose staff is carrying out diagnostic testing for HIV infection, who provides treatment to PLHA, and who has contact with blood and other biological materials of infected persons is obliged to provide employees with necessary means of protection according to the list and normative standards established by the Cabinet of Ministers of Ukraine, as well as conditions for such employees to undergo at-will medical examinations with the purpose of detecting HIV infection.

Employees carrying out works mentioned in part I of this Article whose professional duties when executed put them at risk of HIV infection are obliged to use appropriate means of protection.

Chapter VI

Responsibility for violation of legislation in the HIV/AIDS response domain

Article 31. Refusal to carry out a person's right to medical examination with the purpose of detecting HIV infection; carrying out such an examination without consent of the person examined; improper execution of professional duties by health and pharmaceutical professionals or other specialists that lead to infection of other person (or several people) with HIV; refusal to provide medical care to HIV-positive people or patients with AIDS, as well as disclosure of data on medical examination and its results by health professionals and employees of bodies mentioned in the Part 2 of Article 8, entails liability as prescribed by the law of Ukraine.

Article 32. Knowingly putting at risk of infection or infecting another person (or several people) with HIV by an individual who knew his/her own HIV-positive status entails criminal liability. The guilty party will also compensate for damage that occurred due to provision of medical care and social support to an infected person in the manner prescribed by the law of Ukraine.

Article 33. Indemnity for damage to the health of persons infected with HIV due to the fault of health professionals or lack of safe working conditions created by owners (or bodies authorized by owners) of health facilities, enterprises, institutions, and organizations whose personnel

executes professional duties linked with risk of HIV infection is paid at the expense of the guilty party in the manner prescribed by the legislation of Ukraine.

THE LAW OF UKRAINE on information

This Law asserts the rights of citizens of Ukraine to information and sets forth the legal principles of activities in the information sphere. Proceeding from the Declaration of National Sovereignty of Ukraine (55-12) and the Act on Declaring Independence of Ukraine, this Law asserts Ukraine's informational sovereignty and determines the legal forms of international cooperation in the sphere of information.

Article 37. Documents and information that are not subject to access by request.

Compulsory access to official documents by request shall not apply to documents containing:

- Information duly established as a state secret;
- Confidential information;
- Information relating to operational and investigational activities of the Public Prosecutor's Office, bodies of the Ministry of Interior, the Security Service of Ukraine, interrogation bodies, and courts in cases when such disclosure may harm the investigation or citizens' right to a just and impersonal adjudication or threaten human life or health;
- Information relating to the private life of citizens;
- Documents considered departmental service correspondence (memoranda, communication between subdivisions, etc.), provided that they relate to a given institution's policy and decision-making process, and precede adoption of decisions;
- Information not to be disclosed pursuant to other legislative or normative acts. The institution to whom such a request is addressed may bar access to the requested documents provided that they contain information not be divulged as per another government institution's normative documents and the institution receiving the request does not have the right to decide on the disclosure of such information;
- Financial institutions' information prepared for controlling fiscal authorities.

CRIMINAL CODE OF UKRAINE

Article 130. Infection with HIV or any other incurable contagious disease.

1. Knowingly putting a person at risk of being infected with HIV or any other incurable contagious disease dangerous to human life shall be punishable by detention for a term up to three months, or by restraint of liberty for a term up to five years, or imprisonment for a term up to three years.
2. Infection of another person with HIV or any other incurable contagious disease by a person who was aware of himself or herself being a carrier of the virus shall be punishable by imprisonment for a term of two to five years.
3. Any such acts as provided for by paragraph 2 of this Article, if committed with respect to two or more persons or a minor, shall be punishable by imprisonment of three to eight years.
4. Willful infection of another person with HIV or any other incurable contagious disease dangerous to the person's life shall be punishable by imprisonment for a term of five to ten years.

Article 131. Professional misconduct causing infection of a person with HIV or any other incurable contagious disease.

1. Professional misconduct by a member of medical or pharmaceutical profession or by any other employee that causes infection of a person with HIV or any other incurable contagious disease dangerous to the person's life as a result of neglect or careless discharge of professional duties shall be punishable by restraint of liberty for a term up to three years or imprisonment for the same term with deprivation of the right to occupy certain positions or engage in certain activities for a term up to three years.
2. The same act that causes infection of two or more persons shall be punishable by imprisonment for a term of three to eight years with deprivation of the right to occupy certain positions or engage in certain activities for a term up to three years.

Article 132. Disclosure of information from the medical examination for HIV or any other incurable contagious disease. Disclosure – by a medical officer, a health worker, or an auxiliary employee who obtained the information without authorization – of information that became known in connection with official or professional duties regarding the medical examination for HIV, AIDS, or any other incurable contagious disease dangerous to the person's life and the examination's results shall be punishable by a fine of 50 to 100 tax-free minimum incomes, community service for a term up to 240 hours, correctional labor for a term up to two years, or restraint of liberty for a term up to three years, with or without deprivation of the right to occupy certain positions or engage in certain activities for a term up to three years.

Understanding stress and burnout¹⁴

Many newly trained counselors—often idealistic and enthusiastic—promise themselves that they will never become like some of the more experienced counselors they have known: tired, cynical, frustrated individuals who no longer seem to care about what they do and who have lost their compassion. It is difficult for these new counselors to imagine that the burned out counselors were once idealistic as well.

Nobody starts out in the profession planning for the days when work no longer seems vibrant and exciting. This is why it is important to discuss counselor burnout during training. Anticipating the predictable stresses and strains of VCT counseling and the toll it might have on one's physical and emotional health allows counselors to take steps to minimize these negative effects.

What is stress? Burnout?

“Stress” can be defined as anything that stimulates an individual and increases their level of alertness. Life without stress would be incredibly dull and boring; life with too much stress becomes unpleasant and tiring and may ultimately damage health and well-being. Too much stress interferes with work performance. Stress often originates from an external event or circumstance that places a demand on an individual's inner or external resources. How stressful an event is felt to be depends partly on the individual's resources. If the demands on the person (e.g., disclosing an HIV-positive test result) exceed his or her ability to cope with them, the person experiences stress.

“Burnout” generally refers to a state of mental/physical exhaustion caused by excessive and prolonged stress. It is a gradual process by which a person, in response to prolonged stress and physical, mental, and emotional strain, detaches from work and other meaningful relationships. The result is lowered productivity, cynicism, confusion, and a feeling of being drained, or having nothing more to give. Burnout has been described as a “physical, emotional, psychological, and spiritual phenomenon; an experience of personal fatigue, alienation, and failure.” It also has been described, in regard to people in the helping professions, as a “progressive loss of idealism, energy, and purpose.” The term “burnout” evokes an image of a fire going out or the ashes left over.

The stages of burnout

The physical and emotional exhaustion associated with burnout causes individuals to cut corners in their work (when they used to pride themselves on doing a thorough job). This may cause guilt or shame. Other features are physical, such as an inability to shake off a lingering cold or fever, frequent headaches, and/or sleeplessness. Another sign of burnout is when the thought of going to work in the morning loses its appeal.

As burnout progresses, many experience changes in their outlook. This might involve developing an attitude that pushes others away, or being bitter toward the job. Emotional and

¹⁴ Adapted from VCT TOOLKIT. HIV Voluntary Counseling and Testing. A Reference Guide for Counselors and Trainers. Family Health International. January 2004

behavioral signs such as angry outbursts, obvious impatience or irritability, and/or treating people with apparent contempt are common. This often leads people to experience severely negative feelings toward themselves, others, or, possibly, all humanity. Intense loneliness and alienation are common characteristics of the end stages of burnout, as one's coping structure and psychological defenses wear down. A slight emotional bump can set off an overly sensitive and personal reaction. Mood swings might be common with short highs and long lows.

Thinking about burnout as the culmination of a series of stages may make it easier to recognize. Symptoms associated with the three stages of burnout—stress arousal, energy conservation, and exhaustion—are listed below.

Stage 1: Stress arousal (includes any two of the following symptoms):

- Persistent irritability
- Persistent anxiety
- Periods of high blood pressure
- Grinding one's teeth at night
- Insomnia
- Forgetfulness
- Heart palpitations
- Unusual heart rhythms (skipped beats)
- Inability to concentrate
- Headaches

If any two of these symptoms are present, you may be experiencing Stage 1 of the burnout cycle.

Stage 2: Energy conservation (includes any two of the following):

- Lateness for work
- Procrastination
- Needing three-day weekends
- Decreased sexual desire
- Persistent tiredness in the mornings
- Turning work in late
- Social withdrawal (from friends and/or family)
- Cynical attitudes
- Resentfulness
- Increased coffee/tea/cola consumption
- Increased alcohol consumption
- Apathy

Any two of the above symptoms may signal Stage 2 of the burnout cycle.

Stage 3: Exhaustion (includes any two of the following):

- Chronic sadness or depression
- Chronic stomach or bowel problems
- Chronic mental fatigue
- Chronic physical fatigue
- Chronic headaches
- The desire to "drop out" of society
- The desire to move away from friends, work, and perhaps even family
- Perhaps the desire to commit suicide

Any two of these symptoms may signal Stage 3 of the burnout cycle.

Who burns out?

Almost anyone can experience burnout. Burnout cuts across demographic characteristics, affecting people regardless of age, length of time on the job, marital status, number of dependents, and number of hours worked per week. But some people may be more likely to experience burnout than others. For example:

- Highly committed individuals who hold high expectations of themselves.
- Frontline workers (more than behind the scenes); for example, nurses are more likely to suffer from burnout than physicians.
- Counselors dealing with difficult issues such as HIV.

People suffering from burnout seem to progressively feel a lack of personal accomplishment in their work. There is also evidence that clients can identify a counselor with burnout. It is documented that clients become dissatisfied and tend to be more critical of the “burned out” counselor’s actions and interventions.

Causes (stresses and strains) of counselor burnout

Counselor burnout can be caused by a number of factors. These stresses and strains are enumerated below not to alarm, but to create awareness of the realistic stresses and strains that a counselor might face:

- A strong sense of commitment.
- Job stress.
- Lack of adequate support.
- Isolation and alienation.
- Fear of HIV infection.
- Ostracism and stigma.
- Excessive identification with clients.
- Involvement of family and loved ones in the counseling session.
- Excessive work.
- Increasing responsibilities.
- Diminishing resources.
- Political pressures.
- Client-related issues (e.g., how to inform clients or their partners of test results, especially if they are HIV-positive or a discordant couple; a couple refusing to be separated; conflict between counseling and giving advice; conflict between encouraging a client and giving false hope; the counselor’s own emotions surrounding HIV)..
- Boredom—hour after hour, day after day, year after year clients enter a counselor’s office, tell their stories, ask similar questions, and expect the counselor to do essentially the same thing.

Recognizing burnout

Counselors can recognize burnout by its physical, behavioral, and/or cognitive symptoms, including those listed in the table below.

Burnout symptoms

Physical	Behavioral	Cognitive
Exhaustion	Quickly irritated or frustrated	Exasperation: "I've had enough" or "I can't take this anymore"
Lingering minor illness	Quickness to anger and/or irritability	Ruminating
Frequent headaches and backaches	Prone to prejudice	Emotional numbness, indifference, impoverishment
Sleeplessness	Alcohol and/or drug abuse	Emotional hypersensitivity
Gastrointestinal disturbances	Marital or relationship problems	Over-identification
Chronic and vague physical pains	Rigidity (inflexibility) in problem solving	Pessimism, helplessness, hopelessness
General malaise	Impulsivity or acting out	Grief and sadness

The visible effects of burnout in HIV counseling are high turnover, absenteeism, declining quality of service, decreasing communication, disorganization, declining enthusiasm, and increasing client complaints.

Stress management

"Stress management" refers to efforts to control or reduce the tension felt when a situation is perceived to be especially difficult or beyond one's resources. Heavy demand and high performance expected of VCT counselors make them continue to work hard in the face of high sustained stress. Thus, it is essential that counselors learn to pay attention to their own needs and feelings. This means knowing when to relax, get more sleep, or implement stress-management strategies. If counselors do not take feeling tired, upset, or discontent seriously, they may face failure, burnout, or breakdown. Counselors ought to:

- Take care of their single most important instrument: *themselves*;
- Be aware of the causes of burnout;
- Know how to recognize and remedy burnout;
- Know how to prevent burnout.

To recognize burnout in themselves, counselors can ask the following questions:

- If I were "burning out"...what signs do you think my clients would see first?
- Who would be the first person to notice that I was burning out? ...Me, my clients, my family, a friend, a colleague, or a supervisor?
- Have I ever noticed that someone I work with is burning out? What did I notice and how did I respond?

A burnout risk survey has been used to help counselors recognize burnout. The questions in the survey do not predict burnout, but might help identify individuals at risk of burnout. For example, answering "yes" to three of the questions indicates risk; answering "yes" to more than four suggests high risk. The same items can be used to identify corrective actions and hence prevent burnout.

What can medical providers do to prevent burnout?

- Ensure that there is an opportunity for individual, peer, or group supervision or counseling for medical providers (if available).
- Be associated with committed, concerned colleagues who can help identify risk of burnout, analyze the situation, and decide on corrective actions.
- Draw support from a partner, work team, or the work culture (environment).
- Engage in self-assessment.
- Retain an attitude of hope.
- Keep changing the way of working (e.g., alter the counseling style, get different supervision, take on new challenges).
- Learn to accept what one can and cannot control.

Counseling for medical providers

If possible, VCT counselors themselves should go for counseling. Evidence suggests that "...counselors cannot hope to open doors for clients that they have not opened for themselves." Counseling for medical providers can have several benefits. By experiencing counseling from the client perspective, the medical provider can:

- Consider their motivation for wanting to be a counselor;
- Find support as they struggle to be a professional;
- Receive help dealing with personal issues that surface through interactions with clients.

Coping strategies for stress and burnout

There are several strategies to cope with stress and burnout. The techniques selected by the medical providers will depend on the cause of the stress and burnout and the situation in which stress occurs. Thus, medical providers should ask themselves where the stress is coming from. For example, if important events and relationship difficulties are causing stress, a positive thinking or imagery-based technique (changing the way we think) may be useful. Where stress and fatigue are long-term, lifestyle and organizational changes (adopting a healthy lifestyle and time management) may be appropriate. If feelings of stress come from within (caused by anxiety, worries about client results, issues beyond their control, or anxiety based on their own behavior), relaxation techniques might be more appropriate.

Adopting a healthy lifestyle

Medical providers can care for themselves by talking to others (friends, family members, colleagues, supervisors) about their stress and asking for help when needed. They can try physical exercise and/or recreation, avoid smoking, drink alcohol only in moderate quantities, adopt an adequate sleep routine, and eat balanced and regular meals. They can withdraw or confront the stressful situation, directly targeting a mood change and shifting the focus from counseling exclusively (i.e., by broadening their focus, interests, and activities). The medical providers should try to get plenty of rest. A common stress reaction is for people to bury themselves in work or activity. This can be self-defeating physically and mentally. If sleep is interrupted, the counselor should get up and replenish himself/herself by having a glass of orange juice or milk, eating, reading, talking, or writing about pressing feelings. After a while the counselor should return to bed.

Managing time

Medical providers can better manage their time by working more efficiently, rather than harder. A range of skills might help in time management: assessing value and use of time, setting goals and routines, creating more time, managing and avoiding distractions, increasing productivity and personal effectiveness, and choosing priorities. For effective time management, it is

important to learn to say “no,” plan projects or duties so they are done properly with adequate resources, do one thing at a time, and break down large tasks into manageable components.

Changing the way one thinks

Sources of stress sometimes can be recast or neutralized by transforming negatives into positives. For example, if counselors experience significant stress from other people, or realize they are not in control of their life, they can eliminate negative feelings by having a more positive outlook, keeping things in perspective, setting personal goals, welcoming changes, or recognizing and changing irrational beliefs. It is important to avoid generalizing, focusing on unimportant details, jumping to conclusions, “making mountains out of molehills,” and taking things too personally. In addition to positive thinking, counselors can employ an imagery method. With imagery, a person substitutes actual experience with scenes from his or her imagination. The body will react to the imagined scenes almost as if they were real. Imagining pleasant scenes can reduce stress.

Employing relaxation techniques

Relaxation techniques are often effective in managing stress when stress appears to be coming from within. Meditation helps one feel peaceful, relaxing the body and clearing the mind of stressful thoughts. Concentrating on one thing for an extended period (possibly 20-30 minutes) helps achieve the desired effect; the focus of one’s concentration might be breathing, an object, a sound, or an imagined scene. Progressive muscular relaxation and deep breathing are purely physical techniques for relaxing tense muscles and calming stress. They can be used in conjunction with mental techniques such as imagery or meditation.

Developing boundaries between personal and professional lives

It is critical that counselors maintain boundaries between their professional and home lives. Medical providers should regulate the balance between their work life and personal life so that work does not consume all of their time. Some counselors may find it easier to maintain the boundaries by avoiding work-oriented social networks. It is also helpful to develop a decompression routine—a ritual that signals one part of life is ending and another part is beginning (i.e., the workday is ending and the personal life is beginning). These routines help the medical providers diffuse emotional energy from work and enter their personal lives in a relaxed manner.

Burnout risk survey

	Yes	No
Do you derive your self-esteem from achievements?		
Is your personal identity tied to your work role or professional identity?		
Do you tend to withdraw from offers of support?		
Will you ask for/accept help?		
Do you always make excuses, like “it is faster to do it myself than to show or tell someone?”		
Do you always prefer to work alone?		
Do you have a close confidant with whom you feel safe discussing problems?		
Do you “externalize” blame (obsessively seek to place blame away from yourself)?		
Are your work relationships asymmetrical? Are you always giving?		
Do you value commitment to yourself to exercise/relax as much as you value those of others?		
Do you often overload yourself or have difficulty saying “no”?		
Do you have few opportunities for positive and timely feedback outside your work?		