



## HIV Counselling: Its Nature & Purpose

In counselling, two people, not related to each other, meet to resolve a crisis, solve a problem, or make decisions involving highly personal and intimate matters. Promoting the well-being and problem solving skills requires continuous gradation between detachment and closeness, within which the counsellor must find the correct balance; of the client.

HIV /AIDS counselling has two general objectives: (1) To provide psychological support to those already affected; and (2) to prevent HIV infection by changing

lifestyles and life style behaviour.

The Counseling process can:

1. Ensure passing on of correct information
2. Provide support at times of crisis
3. Encourage change when change is needed for the prevention or control of infection.
4. Help clients focus and identify for themselves their immediate and long term needs.
5. Propose realistic action suitably adapted to the different clients and circumstances.
6. Assist clients to accept and act on information on health and well-being; and
7. Help clients to be well-informed and appreciate the technical, social, ethical and legal implication of HIV testing.
8. Give psychological support.



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**WHO IS HIV/AIDS COUNSELING FOR?**

In the context of HIV/AIDS, counseling is recommended for the following:

- Persons and their families, already identified as having AIDS or infected with HIV
- Those being tested for HIV (pre and post-testing)
- Those seeking help because of past or current risk behaviour and planning their future.
- Those not seeking help but who practice high risk behaviour.
- With these priorities in mind, the types of situations in which counselling is of value and people seek care, might include
- People with AIDS or other disease related to their HIV infection
- People experiencing difficulties with employment, housing, finances, family, etc as a result of HIV infection.
- People considering being tested for HIV.
- People who have been tested for HIV (whether or not they are infected);
- The family and friends of people who are infected with HIV
- People worried that they might have become infected with HIV
- Health workers and other professionals who come into regular contact with people infected with HIV
- People who choose not to be tested despite past or present risk behaviour.
- People who are unaware of the risks of HIV infection involved in specific behaviours they have, or are, engaged in.

**WHERE CAN IT BE PROVIDED?**

HIV/AIDS counseling can take place in any settings where there is, or could be, a discussion about HIV/AIDS. Such settings include wards in hospitals, centres for sexually transmitted diseases, antenatal and postpartum clinics, family planning clinics, blood donation centres and sites, drug addiction centres, prisons, community health centres, schools, churches, outpa-

tient clinics, and all health outreach or community-based programmes.

In summary, counseling people about HIV infection is important because:

1. Infection with HIV is lifelong
2. A diagnosis of HIV infection can create enormous psychological pressures and anxieties that can delay constructive change or worsen illness, especially as the HIV epidemic has given rise to fear, misunderstanding and discrimination,
3. Behavioural change can prevent a person acquiring HIV infection or transmitting it to others.

**MAIN FUNCTIONS OF COUNSELING:**

Counseling has two main functions: the provision of social and psychological support to those affected by HIV and the prevention of HIV infection and its transmission to other people.

**PSYCHOLOGICAL SUPPORT:**

People diagnosed as having HIV infection and HIV-related illness, including AIDS, and those close to them are confronted by a host of problems that call for emotional and/or practical support. Anxiety about having spread infection, physical isolation, hospitalization, discrimination within the community or family, loss of housing, intermission of education, financial problems, the physical effects of illness, disease progression, loss of relationships, bereavement, anger, loneliness and depression are all concerns that may have to be managed.

It is important to remember that counseling incorporates a process of empowerment for the person with HIV.

Counseling should help those affected by HIV to live fully and productively by enabling them to resume (or assume) authority over their own lives and decision-making.

**PREVENTION:**

There are five main steps in situations where prevention of HIV infection is the primary goals of the counseling interaction. These are:



1. Determine whether the behaviour of an individual or group of individuals involves a high risk of HIV infections.
2. Working with the people concerned so that they understand and acknowledge the risks associated with their behaviour.
3. Defining with them how their life, attitudes, values and self images is linked to their behaviour.
4. Helping individuals to define their potential for awaited shifts, behaviour modification and change; and
5. Working with individuals to introduce and sustain the modified behaviour.

**PRIMARY PREVENTION:** Counseling for primary prevention is needed by people who are at risk of HIV infection but are not known to be infected.

**SECONDARY PREVENTION:** For persons known or considered likely to be HIV- infected, counseling should emphasize implications of HIV infection and ways to avoid transmission.

Emphasize the importance of adopting practices that eliminate or minimize the possibility of infecting sex partners. Condom use, low risk sexual practices, alternatives ways of seeking gratification and celibacy.

Prevention of transmission through blood or blood products, counseling needs to stress the importance of not donating blood and not sharing syringes, needles or other skin piercing equipment.

Perinatal transmission is also an important concern. In the case of women who are already pregnant, the possibility of interrupting the pregnancy or the desire to do so, will have to be dealt with, taking into account many cultural, familial, emotional and medical factors that can influence such a decision. Prevention of future pregnancies should be discussed.

#### **CONTENT OF COUNSELING:**

HIV / AIDS counseling should therefore include discussion of the following:

- a) the primary need to prevent infection and re-infec-

- b) basic information about HIV infection and associated diseases and means of transmission;
- c) assessment of the level of risk of HIV infection
- d) review of possible sources of a client's infection
- e) specific information on risk reduction by changing risk behaviour, eg through protected or safer sex
- e) exploration of cultural and value obstacles to changing behaviour or adopting safer sexual practices
- f) information about what testing can and cannot do, assessment of the consequences of having the HIV – antibody test
- g) follow – up guidance after testing has been done
- h) how to tell others that one is HIV– infected and
- i) handling hostility, fear and feelings about having HIV infection or being diagnosed as having AIDS
- j) when a person is diagnosed with HIV, counseling must also include
- k) supporting the process of anticipatory grief
- l) planning for continued involvement of the client in self – care
- m) establishing or re- establishing a support network to provide physical and emotional care, during the course of the disease
- n) exploring ways of taking care of survivors and
- o) accepting fear of death and continuing to provide emotional support.

#### **COUNSELING AND RESISTANCE TO CHANGE**

Counseling is one of the principle means of helping people understand why they resist changing their behaviour. The counselor may also need to explore and explain reasons repeatedly and in various ways.

To promote and sustain the behavioural changes needed to prevent HIV transmission. The counsellor needs to work intensively not only with infected or sick persons but also with their families and other people who matter to them. Moreover, the counsellor will have to be sensitive to other people and to attitudes in the social environment, which may inhibit behavioural change or actively promote and support risk behaviour. The people



who should be included in the counselling process will vary in each individual situation and will depend to a certain extent on who the HIV-infected person chooses to be included. Family members, loved ones, friends and colleagues in the workplace all may be involved in the counseling process.

After learning that they are HIV-positive, people may have strong feelings. Most will be shocked. Some people may enter a stage of denial. Many, especially if they feel well, will refuse to accept that they have the disease or that they could harm themselves or other people. HIV infected persons may feel angry and blame themselves or others; some may even want to take revenge by infecting others. Some may enter into a bargain, thinking that they will be cured if they performed a good act. Most will feel lonely and will be afraid of losing their jobs, people rejecting their friendship, their families deserting them, pain, death, etc. Each of the situations mentioned above need counseling. What is likely to move people is concern for spouses or partners and for the children's well-being. Fear alone may not be a sufficient motivation but counsellor must consistently and patiently keep them well aware of the risks and support their efforts to change their behaviours.

**COUNSELING AND HEALTH EDUCATION;**

Psychosocial counseling in relation to HIV infection and health education of the public are the primary ways of:

1. Reducing resistance to behavioural change
2. Helping people adjust to the need to change behaviour
3. Assisting individuals, families and communities to use social, medical, spiritual and economic support systems; and
4. Reinforcing healthy behaviour which may already exist

Health education and counseling both aim at changing risk behaviour.

Finally, counsellors must keep up with current knowledge and combine this knowledge with the skills of listening, supporting and guiding.

**EFFECTIVE COUNSELING TECHNIQUES:**

**QUALITIES OF A GOOD COUNSELLOR**

1. Positive regard or respect for people.
2. Open, non-judgmental and help level of acceptance.
3. Caring and empathetic
4. Self awareness and self disciplined
5. Knowledgeable / informed about subject and awareness of resources available within the community
6. Culturally sensitive
7. Patient and a good listener
8. Ability to maintain confidentiality
9. Objective and having clarity.

**COUNSELING SKILLS:**

1. Active attending or listening.
2. Reflection of feeling
3. Questioning
4. Paraphrasing
5. Interpretation
6. Repeating
7. Summarizing
8. Confrontation
9. Respecting
10. Structuring or prioritization

**ESSENTIAL STAGES OF COUNSELING:**

**Stage One—Forming Rapport and Gaining the Client's Trust.**

The counsellor must spend time in encouraging trust and building a rapport with the client. He/she may do this by letting the clients tell their life/event stories in their own way. The counsellor may find the stories disjointed or rambling but must let them continue, while noting what is highlighted or played down or ignored.

**Stage Two—Definition and understanding of Roles, Boundaries and Needs:**

Explaining and making clear to the client the roles and boundaries of the counseling relationship is an essential part of counseling. Establishing and clarifying the client's needs and goals. With most urgent and important ones



to be addressed first, followed by more general, long term issues also need to be done before ongoing counseling sessions can begin.

### **Stage Three—Process of Ongoing, Supportive Counseling:**

Encouraging the client to begin a consideration of possible options and assessing possible solutions/ decisions and their implication. Ongoing counselling focuses on enabling the client to take charge and move towards change. This stage also involves supporting and encouraging the expression of intense emotions like fear and anger by the client. Discussion of the client's plans for informing and involving the family and other close associates in cases of HIV infection and AIDS also occupies a lot of time and attention. Basically, counseling consists of supporting and sustaining work on the selected problems and monitoring of the progress towards the mutually decided goals.

### **Stage Four—Closure or Ending the Counseling Relationship:**

After the client has shown willingness to formulate plans and has carried some of them through with a certain degree of success, counseling enters the end stage. The counsellor ends the relationship only when it is certain that the client: (1) is maintaining the necessary changes in behavior; (2) can cope and adequately plan for day-to-day functioning; and (3) has a support system (family, friends, support groups etc.). Also, the client should be assured of being able to return to counseling whenever this is necessary.

## **PRE AND POST TEST COUNSELING**

### **1. ROLE OF ANTIBODY TESTING**

Counsellors everywhere have to deal with wrong ideas and even anxieties about HIV antibody testing. The counselor must ensure that the client understands what the test implies and what a positive or negative result means. Many people believe that a positive enzyme-linked immunosorbent assay (ELISA) means that they

have AIDS, and this cause great distress. The counselor must deal with the fear and communicate the facts unambiguously. People whose test is negative may feel relieved and believe they can go on living the same way. Preventive counseling must begin immediately to prevent this attitude. They must be told about the "window period" and what they should do to prevent acquiring or passing on the infection, and be urged to return for follow up counseling.

People who are considering being tested for HIV infection, must be given the information they need to be able to make a well-informed decision on whether to have the test. The information must be up-to-date and cover the technical aspect of testing and its medical and social implications. Confidentiality must be ensured.

### **2. COUNSELLING ISSUES RELATED TO TEST-SEEKING**

Testing raises many questions for the counsellor, not the least of which is, how to assess client's reasons and motivation for seeking a test.

People sometimes donate blood so as to have a pretext for undergoing an antibody test. The counselor should discourage this practice. Those who do so miss the opportunity which counseling offers to discuss safe sexual practices and related matters.

### **3. PRE TEST COUNSELLING**

**3.1 The AIM :** Counseling before the test should provide individuals who are considering being tested, with the information on the technical aspects of screening and on the possible personal, medical, social, psychological and legal implications of being found either HIV-positive or HIV-negative. The information should be given in a manner that is easy to understand and should be up to date.

A decision to be tested should be an informed decision. Informed consent implies awareness of the possible implications of a test result.

**3.2 THE ISSUES:** Pre-test counseling should centre on two main topics: first, the person's personal history and risk of being or having been exposed to HIV (box #1); secondly, the client's understanding of



HIV/AIDS and previous experience in dealing with crisis situations (box # 2).

**BOX # 1: Assessment of Risk**

- Frequency, aid, type of sexual behaviour and specific sexual practices; in particular, high risk practices such as vaginal and anal intercourse without condoms, unprotected sexual relations with commercial sex workers and drug injecting.
- Being part of a group with known high HIV prevalence or with known high-risk lifestyles, e.g injecting drug users, male and female commercial sex workers and their clients, prisoners and homosexual or bisexual men.
- History of blood transfusion, organ transplant, or administration of blood or body products.
- Exposure to possibly non-sterile invasive procedures, such as tattooing and scarification.

**BOX #2: Assessment of Psychological Factors and Knowledge.**

- Why is the test being requested?
- What particular behaviors or symptoms are of concern to the client?
- What does the client know about the test and it uses?
- Has the client considered what to do or how he /she would react if the result was positive or if it was negative?
- What are the client's beliefs and knowledge about HIV transmission and its relationship to risk behaviour?
- Who could provide (and is currently providing) emotional and social support (family, friends, others)?
- Has the client sought testing before and, if so, when, from whom, for what reason, and with what result?

In summary pre-test counseling should: 4

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| <ul style="list-style-type: none"> <li>• Determine what that person understands about HIV and AIDS</li> <li>• Provide factual information as needed</li> <li>• Discuss potential implications of a positive and negative test result</li> </ul> | <ul style="list-style-type: none"> <li>• Explain and obtain informed consent</li> <li>• Review the test procedure</li> <li>• Assess the person's ability to cope with positive result and</li> <li>• Establish a relationship as a basis for post-test counseling.</li> </ul> |
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*Once a decision has been made to take the test for HIV antibodies, Arrangements should be made to prepare for post-test counseling.*

**4. POST-TEST COUNSELING**

HIV testing can have three possible outcomes:

1. A negative result;
1. A positive result;
2. An equivocal result.

**4.1 COUNSELING AFTER A NEGATIVE RESULT**

It is very important to carefully discuss the meaning of

a negative result (whether this was expected or not). The news that the result was negative is likely to produce a feeling of relief or euphoria, but the following points must be emphasized.

- 1) Following possible exposure to HIV, the "window period" must have elapsed before test results can be considered reliable. This means that, in most



cases, a minimum of at least three months have elapsed from the time of possible exposure before a negative test can be considered to mean that infection did not occur. A negative test result carries greatest certainty if at least **six months** have elapsed since the last possible exposure.

- 2) Further exposure to HIV infection can be prevented only by avoiding high-risk behaviours. Safer sex and avoidance of needle-sharing must be fully explained in a way that is understood and permits appropriate choices to be made.
- 3) Other information on control and avoidance of HIV infection, including the development of positive health behaviours, must be counseled to practice together methods of negotiating these with others, in order to assist the client in introducing and maintaining the new behaviour.

#### **4.2 COUNSELING AFTER A POSITIVE RESULT**

People diagnosed as having HIV infection or disease should be told as soon as possible. The first discussion should be held in private and under conditions of confidentiality; the client should be given time to absorb the news. After a period of preliminary adjustment, the client should be given a clear, factual explanation of what this news means. This is not a time for speculation about prognosis or estimates of time left to live, but for acknowledging the shock of the diagnosis and for offering and providing support. It is also a time for encouraging hope that achievable solutions can be found, to the resulting personal and practical problems. Where resources are available, it may also be justifiable to talk about possible treatments for some symptoms with HIV infection and about the efficacy of new antiviral drugs. Important practical information for people with HIV infection must be provided. (see points 3.3 and 3.5) After a positive result, the counseling relationship may enter a new phase. Crisis counseling will always be necessary, and usually also problem-solving counseling. The Pre-test assessment can be used to determine the best way to tell the client about the test result. How the news is accepted will depend on the person's per-

sonality, psychological circumstances. Previous knowledge of HIV, and cultural attitudes towards AIDS. The client must be told how to contact the counselor during periods of severe stress. There should be some discussion of what may happen if employers or others learn that the person is HIV infected. All the information previously given about safer sex, prevention of transmission and maintaining health must be repeated. Follow-up visits must be arranged, often on a routine basis.

The following points need to be repeatedly emphasized:

- 1) HIV infection is not AIDS. Prognosis varies, but every infected person should be encouraged to live a normal social and economic life unless AIDS related symptoms do not permit this. Since normal living requires the support of others, those concerned may need regular counseling to anticipate and cope with new needs.
- 2) A person who is HIV positive should take care of general health. The presence of other infections such as other sexually transmitted diseases or any illnesses will affect the immune response and may hasten the development of AIDS. The counselor must stress the need to avoid exposure to illness as a measure to prolong life. The counselor must explain how the risk of infections can be avoided through general home hygiene and the prevention of other sexually transmitted diseases, emphasizing the use of condoms and reducing the number of sexual partners.
- 3) Spouses and partners will need support; telling them that HIV infection has been found, is difficult and considerable support for this may be needed from the counselor. Bringing spouses or partners in for counseling to prevent transmission and, where indicated, testing is a frequent counseling goal.
- 4) Spouses and partners must be protected against infection. Condoms should be recommended to prevent infection transmission and re-infection of the patient. The counsellor should stress the need for care in ensuring that the condoms are of good qual-



ity and intact. Latex condoms are much safer than animal membrane condoms. The proper and consistent use of condoms should be stressed. The use of condom may not be acceptable in some cultures and countries. Objections to them and the consequences of not using them, need to be discussed.

- 5) Person who is HIV positive should not share their syringes, needles, or other skin-piercing instruments.

In **SUMMARY** after a positive test result, post-test counseling should:

- Ensure that the person understands what a positive HIV test result means.
- Discuss how they feel about being infected.
- Provide support to help the person deal with these feelings;
- Discuss their plans for the immediate future;
- Establish a relationship with the person on a basis for future counseling,
- Schedule appointments for medical evaluation and follow-up counseling;
- Counsel partner(s) if possible; and
- Refer the person to local community services if possible.

#### 4.3 COUNSELING AFTER AN EQUIVOCAL RESULT

A test result may be equivocal for a number of reasons; for instance, there may have been insufficient time for full seroconversion to take place since the possible exposure to HIV occurred (the “window period” previously mentioned). In such circumstances, there are two main issues for the counselor to consider:

1) The test used to determine whether the person is infected with HIV. The first test most commonly used is ELISA, which is 100% sensitive with specificity approaching 99.5%, so that a negative result can be regarded as a definite indicator that the person is not infected, except for tests carried out during the “window period”. Correspondingly, a positive result suggests the possibility of HIV infection. The usual procedure then is to retest, again using ELISA with specificity 100%.

The results of sub supplemental testing can either be positive, strongly indicating HIV infection or negative, indicating HIV infection. In areas with less than 10% prevalence of HIV infection, to diagnose HIV infection, a third ELISA with a specificity of 100% may be carried out on sera positive with first two ELISA tests. If positive, it strongly indicates HIV infection. If it is negative, it is indeterminate. The reasons may be as follows:

- The person has developed non clinical signs of HIV infection more quickly than might normally be expected.
- A related HIV virus is present
- A cross reaction is occurring with a non viral protein and the reaction is simulating that also cited with the HIV p24 core position.

The following options are then available:

- To use alternative methods with the aim of obtaining a reliable result e.g by using combinations of techniques so as to exclude false positive results;
- Not to carry our further testing
- Prevention and support while waiting for an equivocal result. The period of uncertainty following equivocal or indeterminate test results may be three months or longer after the last instance of potentially high-risk exposure or the previous test for HIV infection. It is then important for counselors to emphasize essential prevention messages regarding sexual and drug use activity, body fluid and tissue donation and breast feeding. The person will need to undertake the precautions recommended for HIV positive persons until proven otherwise. Just as importantly, however, the uncertainties associated with this period may lead to acute and severe psychosocial difficulties and the counselor must be prepared to assess and manage such issues or to make appropriate referrals, if necessary in every case.

#### 5. UNRESOLVED ISSUES IN HIV–ANTIBODY TESTING

When someone seeking to be tested gives no history



of high-risk behaviour, the counselor should enquire into the reasons why testing is sought, and offer preventive and supportive counseling. The counselor may discourage people who do not want to know the test result from taking it, but should make it quite clear to them that they must behave as if they were seropositive in order to prevent infection of themselves or transmission to others.

In some places, there is much concern test, without compulsory testing, many people will not admit to risk behaviour and infection will not be detected. The risk must be weighed against the cost to and consequences for social order and civil rights of compulsory testing. Counseling should encourage motivation and voluntary action to bring about behaviour change.

In some places, the counselor may be required to ensure that a client gives written informed consent for certain medical procedures. The counselor should therefore make the following points very clearly:

- No test can tell whether someone has, or will develop AIDS
  - The tests available detect antibodies to HIV in the blood
  - The presence of HIV antibodies (except for passive maternal antibodies in the case of uninfected infants of HIV - infected mothers) is proof only of HIV infection, it does not prove that the person is suffering, or will suffer from HIV-related diseases.
  - It is impossible to tell from a positive HIV test when the person was infected, or for how long. This point is important and needs to be discussed with clients so as to make sure that they understand that HIV infection may have occurred before an existing relationship began and does not necessarily imply that the current partner has been unfaithful.
  - Whether the test is positive or negative, behaviour must often be changed, either to remain negative or to protect others against HIV infection.
  - A negative result does not rule out infection, if there has been risk behaviour. The test should be repeated three months after exposure has occurred to allow for the "window effect".
- Some kinds of behaviour and practices are dangerous to the HIV infected person, because they lead to exposure to other infections, including sexually transmitted diseases; 'safer sex' must become part of the way of life both of the sero-positive person and the sero-negative person who wants to remain sero-negative.

Trust in terms of *confidentially* is one of the most important factors in the relationship between the counselor and the counseled. It enhances that relationship and improves the chances that the person (or group) will act decisively on information provided.

The counselor should tell the client about *any official policy on further testing* for confirming a positive result. For example, the general policy is to follow an initial positive ELISA test with a second one containing a different antigen or principle and, if that is also positive, to confirm with another ELISA test with 100% specificity.

## 6. PRACTICAL INFORMATION FOR PEOPLE WITH HIV INFECTION OR DISEASE

Counseling for support and prevention are needed in the post-test and post-diagnosis phase. In addition to acknowledging and working with the psychological issues that appear at this time, particularly if people are few infected or have HIV disease, the counselor should emphasize *information* that provides the framework for living with HIV. *Similarly, as part of the process, the following points should be covered in all counseling sessions, whether for HIV positive or HIV negative people:*

- 1) HIV infection is *not* the same as AIDS. People with AIDS have HIV infection, but only a proportion of those with HIV have AIDS.
- 2) Sexual intercourse, whether heterosexual or homosexual, is the major route of transmission of HIV. The virus can be transmitted by any penetrative



sexual act in which HIV infected semen, vaginal/cervical secretions, or blood is exchanged. HP~infection can be prevented. During each act of sexual intercourse, men should always use a condom from start to finish. Women should make sure their partners use a new condom for each act of sexual intercourse.

- 3) Condoms, when carefully and consistently used, provide effective protection against HIV transmission. Latex condoms lubricated with a silicone or water-based not oil-based, lubricants should be used. Animal membrane (e.g lambskin) condoms are not believed to be as effective as latex condoms, as a barrier against HIV and are the fore not recommended.
- 4) Non-barrier contraceptives such as intrauterine devices (IUDs) have no protective effect against HIV transmission. It is not clear whether oral or injectable contraceptives affect the risk of HIV transmission. Coordination between AIDS control and family planning services is clearly essential.
- 5) Certain health conditions, especially other sexually transmitted diseases should be followed by people with HIV as well as by those without. This type of information must be clearly explained to the client and, with the explicit agreement of the client, his/her sex partner, if that person is known as accessible.
- 6) It is not yet clear whether pregnancy accelerates the progression of HIV infection to AIDS. The uncertainties about this must be carefully explained to infected women of childbearing age. The risk of transmission to the fetus is 16-39%. If a woman has AIDS, she is much more likely to have problems with the pregnancy. If HIV-infected women want to avoid pregnancy, advice about contraceptives should be given to them and to their sex partners. Access to safe and reliable contraceptive methods must be ensured.
- 7) With regard to immunization, studies have demonstrated that the use of the following vaccines is safe

in children suspected of being infected with HIV-1: BCG, DTP, OPV, IPV, measles vaccine and tetanus toxoid (all the standard vaccines recommended for children). However, BCG should not be used if a child has symptoms of HIV related disease. The safety of other live vaccines, such as yellow fever vaccine, has not been evaluated. In general, where there is a high prevalence of HIV infection, asymptomatic persons should continue to be immunized in accordance with the standard schedules recommended by the WHO Expanded Programme on Immunization (EPI). Further experience continues to support these recommendations, highlighting the benefits of immunization in protecting HIV-1 infected children, particularly against measles and the complications of tuberculosis, immunization in protecting HIV-1 infected children, particularly against measles and the complications of tuberculosis.

- 8) Persons with HIV infection should never donate body fluids, such as blood, semen, and breast milk, or body organs.
- 9) If blood from a person infected with HIV is spilled in the home or workplace, it should be cleaned up with an absorbent material (such as cloth, rag, paper towel, or sawdust), while avoiding direct skin contact with it. The blood-soaked absorbent material should then be washed with a disinfectant (preferably sodium hypochlorite, or household bleach, diluted 1:10 with water) to clean up any excess blood. Household rubber gloves should be worn, if available, when cleaning up blood spills.
- 10) People with HIV infection should not share syringes, needles, or other skin-piercing instruments.
- 11) People with HIV infection should not share toothbrushes, blade razors, or other instruments that could become contaminated with blood.
- 12) Positive Health behaviour needs to be actively encouraged.



**LIVING POSITIVELY WITH AIDS**

A person with AIDS should try to keep the body strong.

This means they should :

Eat a good diet.

Stay as active as possible, to keep fit & regular sleep.

Continue to work, if possible.

Occupy oneself with meaningful or at least distracting activities.

Socialize with friends and family.

Talk to some one about the diagnosis and illness.

Use a condom during sexual intercourse.

Seek medical attention for health problems and follow the advise for care, including counselling and social services.

**And they should avoid:**

Alcohol and cigarettes.

Other infections – including further doses of HIV.

Pregnancy- because it lowers body immunity and some report it can hasten the onset of AIDS in an HIV positive woman.

Using unprescribed drugs

Isolating themselves.

**Reference :**

- (i) Training manual for Doctors: NACO( National Aids Control Organisation
- (ii) Counselling Clients ith H N Diseak By Mary Ann Hoffman



# A Double Blind Placebo Controlled Study: Homoeopathy in HIV Infection

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**ABSTRACT OBJECTIVE:** This study was aimed to evaluate the immuno-modulator role of homoeopathic remedies in HIV infection.

**METHODOLOGY:** A randomized double blind clinical trial was conducted to compare the effect of homoeopathic remedies with placebo, on CD4<sup>+</sup>ve T-lymphocytes in HIV infected individuals, conforming to

CDC stage II & III. 100 HIV<sup>+</sup>ve individuals between 18 and 50 years (71% males) were included in the study. 50 cases conformed to CDC stage II - Asymptomatic HIV infection, and other 50 cases to CDC stage III - PGL. Cases were stratified according to their clinical status and CD4<sup>+</sup>ve Lymphocyte counts. The randomization charts were prepared much before the start